

<b>Molina Medicare Options Plus HMO SNP Member Services</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Hours of operations are Monday through Sunday 8:00 AM to 8:00 PM, local time. Member Services also has free language interpreter services available for non-English speakers.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare P.O. Box 8542 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

<b>HICAP (California HICAP)</b>	
HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.	
<b>CALL</b>	1-800-434-0222
<b>TTY/TDD</b>	711
<b>WRITE</b>	HICAP Sacramento County: 1-800-434-0222 HICAP Services of Northern California 3950 Industrial Blvd., Suite 500 West Sacramento, CA 95691

# Evidence of Coverage

Molina Medicare Options Plus HMO SNP

Sacramento County

**January 1 – December 31, 2012**

# **Evidence of Coverage:**

## **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Molina Medicare Options Plus HMO SNP**

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Molina Medicare Options Plus HMO SNP, is offered by Molina Healthcare of California (When this Evidence of Coverage says “we,” “us,” or “our,” it means Molina Healthcare of California. When it says “plan” or “our plan,” it means Molina Medicare Options Plus HMO SNP.)

*A Coordinated Care plan with a Medicare Advantage contract and a contract with the state Medicaid program.*

This information is available for free in other languages. Please contact our Member Services number at 1-800-665-0898 for additional information. (TTY/TDD users should call 1-800-346-4128). Hours are Monday through Sunday 8:00 AM to 8:00 PM, local time. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible gratuitamente en otros idiomas. Para información adicional favor de comunicarse al departamento de Servicios para Miembros al: 1-800-665-0898. (Para los usuarios del servicio TTY/TDD deberán marcar 1-800-346-4128). Su horario es de lunes a domingo, de 8:00A.M. a 8:00P.M., tiempo local. El departamento de Servicios para Miembros también tiene servicios gratuitos en otros idiomas los cuales están disponibles para personas que no hablan el inglés.

This information is available in a different format, including Spanish, Braille, large print, and audio tapes. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información está disponible en formatos distintos, como en español, Braille, letra grande y cintas de audio. Si necesita información sobre el plan en otro formato o idioma, comuníquese con el Departamento de Servicios al Miembro al número telefónico que figura arriba.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

# 2012 Evidence of Coverage Table of Contents

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This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

<b>Chapter 1. Getting started as a member .....</b>	<b>4</b>
Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
<b>Chapter 2. Important phone numbers and resources .....</b>	<b>14</b>
Tells you how to get in touch with our plan (Molina Medicare Options Plus HMO SNP) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
<b>Chapter 3. Using the plan's coverage for your medical services .....</b>	<b>29</b>
Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.	
<b>Chapter 4. Benefits Chart (what is covered).....</b>	<b>41</b>
Gives the details about which types of medical care are covered and not covered for you as a member of our plan.	
<b>Chapter 5. Using the plan's coverage for your Part D prescription drugs .....</b>	<b>61</b>
Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's List of Covered Drugs (Formulary) to find out which drugs are covered. Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.	
<b>Chapter 6. What you pay for your Part D prescription drugs .....</b>	<b>76</b>
Tells about the four (4) stages of drug coverage (Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the 4 cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.	

## Table of Contents

---

<b>Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs .....</b>	<b>90</b>
Tells when and how to send a bill to us when you want to ask us to pay you back for your covered services or drugs.	
<b>Chapter 8. Your rights and responsibilities.....</b>	<b>95</b>
Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
<b>Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) .....</b>	<b>104</b>
Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
<ul style="list-style-type: none"><li>• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.</li><li>• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.</li></ul>	
<b>Chapter 10. Ending your membership in the plan .....</b>	<b>147</b>
Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
<b>Chapter 11. Legal notices.....</b>	<b>153</b>
Includes notices about governing law and about nondiscrimination.	
<b>Chapter 12. Definitions of important words .....</b>	<b>155</b>
Explains key terms used in this booklet.	

# Chapter 1.

## Getting started as a member of our plan

---

<b>SECTION 1</b>	<b>Introduction .....</b>	<b>5</b>
Section 1.1	You are enrolled in Molina Medicare Options Plus HMO SNP, which is a specialized Medicare Advantage Plan (Special Needs Plan) .....	5
Section 1.2	What is the Evidence of Coverage booklet about?.....	5
Section 1.3	What does this Chapter tell you? .....	6
Section 1.4	What if you are new to Molina Medicare Options Plus HMO SNP? .....	6
Section 1.5	Legal information about the Evidence of Coverage .....	6
<b>SECTION 2</b>	<b>What makes you eligible to be a plan member? .....</b>	<b>7</b>
Section 2.1	Your eligibility requirements.....	7
Section 2.2	What are Medicare Part A and Medicare Part B?.....	7
Section 2.3	What is Medicaid?.....	7
Section 2.4	Here is the plan service area for Molina Medicare Options Plus HMO SNP .....	8
<b>SECTION 3</b>	<b>What other materials will you get from us? .....</b>	<b>8</b>
Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs ....	8
Section 3.2	The Provider/Pharmacy Directory: Your guide to all providers in the plan’s network as well as the network of pharmacies .....	9
Section 3.3	The plan’s List of Covered Drugs (Formulary) .....	10
Section 3.4	The Explanation of Benefits (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs.....	10
<b>SECTION 4</b>	<b>Your monthly premium for Molina Medicare Options Plus HMO SNP... ..</b>	<b>10</b>
Section 4.1	How much is your plan premium? .....	10
Section 4.2	Can we change your monthly plan premium during the year? .....	11
<b>SECTION 5</b>	<b>Please keep your plan membership record up to date.....</b>	<b>11</b>
Section 5.1	How to help make sure that we have accurate information about you.....	11
<b>SECTION 6</b>	<b>We protect the privacy of your personal health information .....</b>	<b>12</b>
Section 6.1	We make sure that your health information is protected.....	12
<b>SECTION 7</b>	<b>How other insurance works with our plan.....</b>	<b>12</b>
Section 7.1	Which plan pays first when you have other insurance?.....	12

# Chapter 1.

## Getting started as a member of our plan

### SECTION 1 Introduction

#### Section 1.1 You are enrolled in Molina Medicare Options Plus HMO SNP, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our plan, Molina Medicare Options Plus HMO SNP.

There are different types of Medicare health plans. Molina Medicare Options Plus HMO SNP is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Molina Medicare Options Plus HMO SNP is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid, you will pay less for some of your Medicare health care services. Medicaid may also provide other benefits to you by covering health care services are not usually covered under Medicare. You will also receive Extra Help from Medicare to pay for the costs of your Medicare prescription drugs. Molina Medicare Options Plus HMO SNP will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Molina Medicare Options Plus HMO SNP is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the California Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

#### Section 1.2 What is the *Evidence of Coverage* booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Molina Medicare Options Plus HMO SNP, is offered by Molina Healthcare of California (When this Evidence of Coverage says “we,” “us,” or “our,” it means Molina Healthcare of California. When it says “plan” or “our plan,” it means Molina Medicare Options Plus HMO SNP.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of Molina Medicare Options Plus HMO SNP.

## Chapter 1. Getting started as a member of our plan

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### Section 1.3 What does this Chapter tell you?

Look through Chapter 1 of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

### Section 1.4 What if you are new to Molina Medicare Options Plus HMO SNP?

If you are a new member, then it's important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact our plan's Member Services (contact information is on the back cover of this booklet).

### Section 1.5 Legal information about the *Evidence of Coverage*

#### It's part of our contract with you

This Evidence of Coverage is part of our contract with you about how Molina Medicare Options Plus HMO SNP covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Molina Medicare Options Plus HMO SNP between January 1, 2012 and December 31, 2012.

#### Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Molina Medicare Options Plus HMO SNP each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

# Chapter 1.

## Getting started as a member of our plan

### SECTION 2 What makes you eligible to be a plan member?

#### Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you are entitled to Medicare Part A
- -- and -- you are enrolled in Medicare Part B
- -- and -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- and -- you meet the special eligibility requirements described below.

#### Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits.

#### Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

#### Section 2.3 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

## Chapter 1. Getting started as a member of our plan

### Section 2.4 Here is the plan service area for Molina Medicare Options Plus HMO SNP

Although Medicare is a Federal program, Molina Medicare Options Plus HMO SNP is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in California: Sacramento



If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

### SECTION 3 What other materials will you get from us?

#### Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:

Molina Medicare Member: Member #: <hr/> PCP: PCP Phone: Medical Copays: Office Visits: \$0 Specialist Visits: \$0 Urgent Care: \$ ER Visits: \$0  Issue ID: Issued Date:	  RxBIN: RXPCN: RxGrp: RxID:   Prescription Drug Coverage
	H5628-001

<p><b>Member Services:</b> 1-800-665-3086 or TTY at 1-800-346-4128                  Monday – Sunday, 8:00 AM to 8:00 PM local time.                  24-Hour Nurse Advice Line: 1-888-275-8750                  24-Hour Nurse Advice Line TTY: 1-866-735-2922                  For Spanish Please Call: 866-648-3537.  <b>Providers/Hospitals:</b> For prior authorization, eligibility and general information, please call Member Services.  <b>Submit Claims To:</b>                  Medical/Hospital:                  PO BOX 22811, Long Beach, CA 90801 please call Member Services (see above).                  Pharmacy:                  7050 Union Park Ave, Suite 200, Midvale, UT 84047 please call Member Services (see above).  <a href="http://www.molinamedicare.com">www.molinamedicare.com</a></p>
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As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

**Here's why this is so important:** If you get covered services using your red, white, and blue Medicare card instead of using your Molina Medicare Options Plus HMO SNP membership card while you are a plan member, you may have to pay the full cost yourself.

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

## Chapter 1.

# Getting started as a member of our plan

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### Section 3.2 The Provider/Pharmacy Directory: Your guide to all providers in the plan's network as well as the network of pharmacies

Every year that you are a member of our plan, we will send you either a new Provider/Pharmacy Directory or an update to your Provider/Pharmacy Directory. This directory lists our network providers with the Medicaid indicator that denotes those providers also accepting Medicaid. Additionally, the directory lists the network pharmacies.

#### What are “network providers”?

**Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

#### What are “network pharmacies”?

Our Provider/Pharmacy Directory gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

#### Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Molina Medicare Options Plus HMO SNP authorizes use of out-of-network providers. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information about emergency, out-of-network, and out-of-area coverage. For more information on Medicaid-covered benefits you should contact your State Medicaid office (the contact information is listed in Chapter 2 Section 6).

It is important that you know who your Medicaid providers are. In some cases, we may not provide your Medicaid coverage. If we do provide your Medicaid coverage, it is important that you go to our Medicaid provider to get your Medicaid services. Our Medicaid providers have an agreement with us to accept our payment for your medical care. When you see one of our network providers, you usually pay nothing for covered services. If you have Medicaid with us, and do not know who our Medicaid providers are, you can call Member Services (phone numbers are on the back cover of this booklet). If you do not have Medicaid with us, you should check with your Medicaid health plan to find out who your Medicaid providers are.

If you don't have your copy of the Provider/Pharmacy Directory, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the Provider/Pharmacy Directory at [www.molinamedicare.com](http://www.molinamedicare.com) or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

#### Why do you need to know about network pharmacies?

You can use the Provider/Pharmacy Directory to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the Provider/Pharmacy Directory, you can get a copy from Member Services (phone numbers are on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at [www.molinamedicare.com](http://www.molinamedicare.com).

## Chapter 1.

# Getting started as a member of our plan

### Section 3.3 The plan's *List of Covered Drugs (Formulary)*

The plan has a List of Covered Drugs (Formulary). We call it the “Drug List” for short. It tells which prescription drugs are covered by Molina Medicare Options Plus HMO SNP. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare and Medicaid. Medicare and Medicaid have approved the Molina Medicare Options Plus HMO SNP Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.molinamedicare.com](http://www.molinamedicare.com)) or call Member Services (phone numbers are on the back cover of this booklet).

### Section 3.4 The Explanation of Benefits (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs

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

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

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Member Services.

## SECTION 4 Your monthly premium for Molina Medicare Options Plus HMO SNP

### Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for Molina Medicare Options Plus HMO SNP. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

### Some members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most Molina Medicare Options Plus HMO SNP members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- Your copy of Medicare & You 2012 gives information about these premiums in the section called “2012 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2012 from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

## Chapter 1.

# Getting started as a member of our plan

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- Additionally, for more information on Medicaid coverage you should contact your State Medicaid office (the contact information is listed in Chapter 2 Section 6).

### Section 4.2 Can we change your monthly plan premium during the year?

**No.** We are not allowed to begin charging a monthly plan premium during the year

However, in some cases, you may need to start paying or may be able to stop paying a Late Enrollment Penalty. (The Late Enrollment Penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year:

- If you currently pay the penalty and become eligible for Extra Help during the year, you would no longer pay your penalty.
- If the Extra Help program is currently paying your Late Enrollment Penalty and you lose your eligibility during the year, you would need to start paying your penalty.

You can find out more about the Extra Help program in Chapter 2, Section 7.

## SECTION 5 Please keep your plan membership record up to date

### Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

#### Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are on the back cover of this booklet).

## Chapter 1. Getting started as a member of our plan

### **Read over the information we send you about any other insurance coverage you have**

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are on the back cover of this booklet).

### **SECTION 6 We protect the privacy of your personal health information**

#### **Section 6.1 We make sure that your health information is protected**

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

### **SECTION 7 How other insurance works with our plan**

#### **Section 7.1 Which plan pays first when you have other insurance?**

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

## Chapter 1. Getting started as a member of our plan

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These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

## Chapter 2. Important phone numbers and resources

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<b>SECTION 1</b>	<b>Molina Medicare Options Plus HMO SNP contacts</b> (how to contact us, including how to reach Member Services at the plan) .....	15
<b>SECTION 2</b>	<b>Medicare</b> (how to get help and information directly from the Federal Medicare program) .....	20
<b>SECTION 3</b>	<b>State Health Insurance Assistance Program</b> (free help, information, and answers to your questions about Medicare) .....	21
<b>SECTION 4</b>	<b>Quality Improvement Organization</b> (paid by Medicare to check on the quality of care for people with Medicare) .....	22
<b>SECTION 5</b>	<b>Social Security</b> .....	23
<b>SECTION 6</b>	<b>Medicaid</b> (a joint Federal and state program that helps with medical costs for some people with limited income and resources) .....	24
<b>SECTION 7</b>	<b>Information about programs to help people pay for their prescription drugs</b> .....	26
<b>SECTION 8</b>	<b>How to contact the Railroad Retirement Board</b> .....	28

## Chapter 2.

### Important phone numbers and resources

#### SECTION 1 Molina Medicare Options Plus HMO SNP contacts (how to contact us, including how to reach Member Services at the plan)

#### How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Molina Medicare Options Plus HMO SNP Member Services. We will be happy to help you.

<b>Member Services</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time. Member Services also has free language interpreter services available for non-English speakers.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare Attention: Member Services 7050 Union Park Center, Suite 200 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

#### How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You may call us if you have questions about our coverage decision process.

<b>Coverage Decisions for Medical Care</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare P.O. Box 8542 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

## Chapter 2.

### Important phone numbers and resources

#### How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Appeals for Medical Care</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 AM to 8:00 PM local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare P.O. Box 8542 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

#### How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Complaints about Medical Care</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 AM to 8:00 PM local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare P.O. Box 8542 Midvale, UT 84047

## Chapter 2.

### Important phone numbers and resources

#### How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Coverage Decisions for Part D Prescription Drugs</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-866-771-0117
<b>WRITE</b>	Molina Medicare 7050 Union Park Center Drive Suite 200 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

#### How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Appeals for Part D Prescription Drugs</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-866-771-0117
<b>WRITE</b>	Molina Medicare 7050 Union Park Center Drive, Suite 200 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

## Chapter 2. Important phone numbers and resources

### How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Complaints about Part D prescription drugs</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-866-771-0117
<b>WRITE</b>	Molina Medicare 7050 Union Park Center Drive Suite 200 Midvale, UT 84047

## Chapter 2. Important phone numbers and resources

### Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking us to pay a bill you have received for covered medical services or drugs).

**Please note:** If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

<b>Payment Requests – Part C</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare Attention: Member Services 7050 Union Park Center, Suite 200 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com"><u>www.molinamedicare.com</u></a>

<b>Payment Requests – Part D</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-866-771-0117
<b>WRITE</b>	Molina Medicare Attention: Member Services 7050 Union Park Center, Suite 200 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com"><u>www.molinamedicare.com</u></a>

## Chapter 2. Important phone numbers and resources

### SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

<b>Medicare</b>	
<b>CALL</b>	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
<b>TTY/TDD</b>	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
<b>WEBSITE</b>	<p><b><u><a href="http://www.medicare.gov">http://www.medicare.gov</a></u></b></p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> <li>• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”</li> <li>• <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health &amp; Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.</li> </ul> <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p>

## Chapter 2. Important phone numbers and resources

### **SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)**

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

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

HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<b>California HICAP</b>	
<b>CALL</b>	1-800-434-0222
<b>TTY/TDD</b>	711
<b>WRITE</b>	HICAP Sacramento County: 1-800-434-0222 HICAP Services of Northern California 3950 Industrial Blvd., Suite 500 West Sacramento, CA 95691

## Chapter 2. Important phone numbers and resources

### **SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)**

There is a Quality Improvement Organization for each state. For California, the Quality Improvement Organization is called Health Services Advisory Group of California.

Health Services Advisory Group of California has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Health Services Advisory Group of California is an independent organization. It is not connected with our plan.

You should contact Health Services Advisory Group of California in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

<b>Health Services Advisory Group of California</b>	
<b>CALL</b>	1-800-841-1602
<b>TTY/TDD</b>	711
<b>WRITE</b>	Health Services Advisory Group of California 700 N. Brand Blvd., Suite 370 Glendale, CA 91203
<b>WEBSITE</b>	<a href="http://www.hsag.com">www.hsag.com</a>

## Chapter 2. Important phone numbers and resources

### SECTION 5 Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

<b>Social Security Administration</b>	
<b>CALL</b>	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY/TDD</b>	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">http://www.ssa.gov</a>

## Chapter 2. Important phone numbers and resources

### **SECTION 6 Medicaid(a joint Federal and state program that helps with medical costs for some people with limited income and resources)**

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

Because you are enrolled in Molina Medicare Options Plus HMO SNP, you are enrolled in both Medicare and Medicaid. This means that your medical services may be covered by Medicare and some may be covered by Medicaid. If you are unsure which services we cover, please contact Member Services (phone numbers are listed on the back cover of this booklet).

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

If you have questions about the assistance you get from Medicaid, contact California Department of Health Care Services' Medi-Cal Program.

<b>California Department of Health Care Services' Medi-Cal Program</b>	
<b>CALL</b>	Sacramento County 1-916-874-2256
<b>TTY</b>	711
<b>WRITE</b>	California Department of Health Care Services P.O. Box 997413 Sacramento, CA 95899-7413

The Medi-Cal Managed Care Office of the Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

<b>Medi-Cal Managed Care Office of the Ombudsman</b>	
<b>CALL</b>	1-888-452-8609
<b>WEBSITE</b>	<a href="mailto:MMCDOmbudsmanOffice@dhcs.ca.gov"><u>MMCDOmbudsmanOffice@dhcs.ca.gov</u></a>

## Chapter 2. Important phone numbers and resources

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The WISE & Healthy Aging Long-Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<b>WISE &amp; Healthy Aging Long-Term Care Ombudsman Program</b>	
<b>CALL</b>	(310) 394-9871 (310) 393-3618 (800) 334-9473
<b>TTY/TDD</b>	711
<b>WRITE</b>	WISE & Healthy Aging Headquarters 1527 4th St., 2nd Floor Santa Monica, CA 90401
<b>WEBSITE</b>	<a href="http://www.aging.ca.gov/programs/ombudsman.asp">www.aging.ca.gov/programs/ombudsman.asp</a>

## Chapter 2. Important phone numbers and resources

### SECTION 7 Information about programs to help people pay for their prescription drugs

#### Medicare's "Extra Help" Program

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

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- The Best Available Evidence (BAE) located on the web at [www.cms.gov/PrescriptionDrugCovContra/17\\_Best\\_Available\\_Evidence\\_Policy.asp](http://www.cms.gov/PrescriptionDrugCovContra/17_Best_Available_Evidence_Policy.asp).

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 or they may call Member Services to request assistance. Acceptable forms of evidence are:

- SSA Award Letter
- Notice of Award
- Supplemental security Income
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions. (phone numbers are listed on the back cover of this booklet)

#### Medicare Coverage Gap Discount Program

Because you get "Extra Help" from Medicare to pay for your prescription drug plan costs, the Medicare Coverage Gap Discount Program does not apply to you. You already have coverage for your prescription drugs during the coverage gap through the Extra Help program.

For people who don't get Extra Help, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap. These enrollees also receive some coverage for generic drugs. If you have any questions about the Medicare Coverage Gap Discount Program, please contact Member Services (phone numbers are on the back cover of this booklet).

## Chapter 2. Important phone numbers and resources

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### **What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?**

Most of our members get “Extra Help” from Medicare to pay for their prescription drug plan costs. If you get “Extra Help,” the Medicare Coverage Gap Discount Program does not apply to you. If you get Extra Help, you already have coverage for your prescription drug costs during the coverage gap.

### **What if you don’t get a discount, and you think you should have?**

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next Explanation of Benefits (EOB) notice. If the discount doesn’t appear on your Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048.

## Chapter 2. Important phone numbers and resources

### SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

<b>Railroad Retirement Board</b>	
<b>CALL</b>	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
<b>TTY/TDD</b>	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are not free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">http://www.rrb.gov</a>

## Chapter 3. Using the plan’s coverage for your medical services

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<b>SECTION 1</b>	<b>Things to know about getting your medical care covered as a member of our plan .....</b>	<b>30</b>
Section 1.1	What are “network providers” and “covered services”? .....	30
Section 1.2	Basic rules for getting your medical care covered by the plan .....	30
<b>SECTION 2</b>	<b>Use providers in the plan’s network to get your medical care.....</b>	<b>31</b>
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care.....	31
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP? .....	33
Section 2.3	How to get care from specialists and other network provider .....	33
Section 2.4	How to get care from out-of-network providers .....	34
<b>SECTION 3</b>	<b>How to get covered services when you have an emergency or urgent need for care .....</b>	<b>35</b>
Section 3.1	Getting care if you have a medical emergency .....	35
Section 3.2	Getting care when you have an urgent need for care .....	36
<b>SECTION 4</b>	<b>What if you are billed directly for the full cost of your covered services?.....</b>	<b>36</b>
Section 4.1	You can ask the plan to pay for your covered services.....	36
Section 4.2	What should you do if services are not covered by our plan? .....	36
<b>SECTION 5</b>	<b>How are your medical services covered when you are in a “clinical research study”?.....</b>	<b>37</b>
Section 5.1	What is a “clinical research study”?.....	37
Section 5.2	When you participate in a clinical research study, who pays for what?.....	38
<b>SECTION 6</b>	<b>Rules for getting care covered in a “religious non-medical health care institution”.....</b>	<b>39</b>
Section 6.1	What is a religious non-medical health care institution? .....	39
Section 6.2	What care from a religious non-medical health care institution is covered by our plan? .....	39
<b>SECTION 7</b>	<b>Rules for ownership of durable medical equipment.....</b>	<b>40</b>
Section 7.1	Will you own your durable medical equipment after making a certain number of payments under our plan?.....	40

## Chapter 3. Using the plan's coverage for your medical services

### SECTION 1 Things to know about getting your medical care covered as a member of our plan

This chapter tells things you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan, use the benefits chart in the next chapter, Chapter 4 (Benefits Chart, what is covered).

#### Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

#### Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare and Medicaid health plan, Molina Medicare Options Plus HMO SNP must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules for these services.

Molina Medicare Options Plus HMO SNP will generally cover your medical care as long as:

- **The care you receive is included in the plan's Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a “referral.” For more information about this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

## Chapter 3. Using the plan's coverage for your medical services

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this case prior authorization is required. Please contact Member Services for assistance (the contact information is located on the back of this booklet). In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter. If you obtain routine care from out-of-network providers without prior authorization, neither Medicare nor the Plan will be responsible for the costs.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

### SECTION 2 Use providers in the plan's network to get your medical care

#### Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

##### What is a "PCP" and what does the PCP do for you?

When you become a member of our Plan, you must choose a network provider to be your Primary Care Physician (PCP). Your PCP can be a physician, nurse practitioner, or other health care professional who meets state requirements and is trained to give you basic medical care. Health professionals are eligible to provide services as PCPs in our Plan when they practice in the areas of family medicine, general practice, geriatrics, internal medicine or obstetrics/gynecology. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

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

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 3 tells you how we will protect the privacy of your medical records and personal health information.

## Chapter 3.

# Using the plan's coverage for your medical services

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### How do you choose your PCP?

Your relationship with your PCP is an important one. We strongly recommend that you choose a PCP close to home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship easier. For a copy of the most current provider directory, or to seek additional assistance in choosing a PCP, please contact Member Services. If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. 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.

### Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

Molina Medicare has a Continuity-of-Care Policy that allows members continued access to non-contracted practitioners in the following situations:

1. Discontinuation of a contract between Molina Medicare and a practitioner or facility.
2. New member in an "active course of treatment" with a non-contracted practitioner at the time of enrollment.
3. New member in the second or third trimester of pregnancy, or up to 60 days postpartum at time of enrollment.

Molina Medicare staff will arrange for continuation of care for up to 90 days for medical, surgical, and mental health or chemical dependency issues or for pregnant members for the duration of the pregnancy and up to 60 days postpartum. The lack of a contract with the physician of a newly enrolled member or discontinued contracts between Molina and a practitioner will not interfere with this option. Molina Medicare will work with the member and non contracted practitioner to transition care within the Molina Medicare network during this continuity of care time period. Continuity of care will be administered within all applicable benefit limits.

#### *Exceptions to Policy:*

1. Molina Medicare staff may extend the 90 day period as long as necessary to meet unusual member needs
2. Molina will not approve continued care by a non-participating provider if:
  - The member only requires monitoring of a chronic condition;
  - The discontinued contract is based on a professional review action for practitioner incompetence or inappropriate conduct, and the welfare of the member would be in jeopardy;
  - The practitioner is unwilling to continue care of the member;
  - Care with the non-participating provider was initiated after the member has been enrolled with Molina;
  - The provider who would do the ongoing care either did not meet Molina's credentialing policies/criteria in the past or attempts to become credentialed while providing ongoing care and does not meet the credentialing policies/criteria.

## Chapter 3.

# Using the plan's coverage for your medical services

### Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- 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.
- Flu shots and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.
- 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.)

### Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

For some types of referrals, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization").

It is very important to get a referral (approval in advance) from your PCP before you see a network specialist or certain other providers (there are a few exceptions, including routine women's health care). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself. If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.**

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists. Each plan PCP has certain network specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a network specialist that your current PCP can't refer you to. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

## Chapter 3.

# Using the plan's coverage for your medical services

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### What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan.

We will call you (up to three times) to notify you that the provider (specialist or PCP) is leaving the network. We will also offer to locate another provider for you to see. We will send you a written notification 30 days prior to the provider leaving the network. If an urgent situation arises please call member services at the number listed in Chapter 2 Molina Medicare has a Continuity-of-Care Policy that allows members continued access to non-contracted practitioners in the following situations:

1. Discontinuation of a contract between Molina Medicare and a practitioner or facility.
2. New member in an "active course of treatment" with a non-contracted practitioner at the time of enrollment.
3. New member in the second or third trimester of pregnancy, or up to 60 days postpartum at time of enrollment.

Molina Medicare staff will arrange for continuation of care for up to 90 days for medical, surgical, and mental health or chemical dependency issues or for pregnant members for the duration of the pregnancy and up to 60 days postpartum. The lack of a contract with the physician of a newly enrolled member or discontinued contracts between Molina and a practitioner will not interfere with this option. Molina Medicare will work with the member and

noncontracted practitioner to transition care within the Molina Medicare network during this continuity of care time period. Continuity of care will be administered within all applicable benefit limits.

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1. Molina Medicare staff may extend the 90 day period as long as necessary to meet unusual member needs
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  - The member only requires monitoring of a chronic condition;
  - The discontinued contract is based on a professional review action for practitioner incompetence or inappropriate conduct, and the welfare of the member would be in jeopardy;
  - The practitioner is unwilling to continue care of the member;
  - Care with the non-participating provider was initiated after the member has been enrolled with Molina;
  - The provider who would do the ongoing care either did not meet Molina's credentialing policies/criteria in the past or attempts to become credentialed while providing ongoing care and does not meet the credentialing policies/criteria.

### Section 2.4 How to get care from out-of-network providers

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this case a prior authorization is required. Please contact Member Services for assistance (the contact information is located on the back of this booklet). If you obtain routine care from out-of-network providers without prior authorization, neither Medicare nor the Plan will be responsible for the costs.

## Chapter 3. Using the plan's coverage for your medical services

### SECTION 3 How to get covered services when you have an emergency or urgent need for care

#### Section 3.1 Getting care if you have a medical emergency

#### What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services at the number on the back of the Plan Membership ID card.

#### What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

Your plan has a supplemental benefit called Worldwide Coverage that has a \$10,000 limit per year. Worldwide Coverage includes urgent/emergent and post stabilization care. (Please refer to Chapter 4 for more information on this supplemental benefit.)

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

#### What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – or – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

## Chapter 3. Using the plan's coverage for your medical services

### Section 3.2 Getting care when you have an urgent need for care

#### What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

#### What if you are in the plan's service area when you have an urgent need for care?

In most other situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

#### What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Your plan has a supplemental benefit called Worldwide Coverage that has a \$10,000 limit per year. Worldwide coverage includes urgent/emergent and post stabilization care. (Please refer to Chapter 4 for more information on this supplemental benefit.)

## SECTION 4 What if you are billed directly for the full cost of your covered services?

### Section 4.1 You can ask the plan to pay for your covered services

If you have paid for your covered services, or if you have received a bill for covered medical services, go to Chapter 7 (Asking us to pay a bill you have received for covered medical services or drugs) for information about what to do.

### Section 4.2 What should you do if services are not covered by our plan?

Molina Medicare Options Plus HMO SNP covers all medical services that are medically necessary, are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

Additionally, you should contact your State Medicaid office for more information on Medicaid-covered services (the contact information is listed in Chapter 2, Section 6) to understand all your coverage options.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back cover of this booklet to get more information about how to do this.

## Chapter 3.

# Using the plan's coverage for your medical services

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For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. If you pay for costs once a benefit limit has been reached, these costs will count towards your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

### **SECTION 5 How are your medical services covered when you are in a "clinical research study"?**

#### **Section 5.1 What is a "clinical research study"?**

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this Evidence of Coverage).

Additionally, you should contact your State Medicaid office for more information on clinical research studies (the contact information is listed in Chapter 2, Section 6) to understand all your coverage options.



















































## Chapter 5. Using the plan's coverage for your Part D prescription drugs



### How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

## SECTION 1 Introduction

### Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

In addition to your coverage for Part D drugs, Molina Medicare Options Plus HMO SNP also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (Benefits Chart, what is covered) tells about the benefits for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (Benefits Chart, what is covered) tells about the coverage for Part B drugs.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits.

You should contact your State Medicaid office for more information on Medicaid-covered drugs (the contact information is listed in Chapter 2 Section 6).

**This chapter explains rules for using your coverage for Medicare Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

### Section 1.2 Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a network provider (a doctor or other prescriber) write your prescription. (For more information, see Section 2, Your prescriptions should be written by a network provider.)
- You must use a network pharmacy to fill your prescription. (See Section 3, Fill your prescriptions at a network pharmacy or through the plan's mail-order service.)
- Your drug must be on the plan's List of Covered Drugs (Formulary) (we call it the “Drug List” for short). (See Section 4, Your drugs need to be on the plan's “Drug List.”)

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

## SECTION 2 Your prescriptions should be written by a network provider

### Section 2.1 In most cases, your prescription must be from a network provider

You need to get your prescription (as well as your other care) from a provider in the plan's provider network. This person would often be your primary care provider (your PCP). It could also be another professional in our provider network if your PCP has referred you for care.

To find network providers, look in the Provider/Pharmacy Directory.

**The plan will cover prescriptions from providers who are not in the plan's network only in a few special circumstances.**

These include:

- Prescriptions you get in connection with covered emergency care.
- Prescriptions you get in connection with covered urgently needed care when network providers are not available.

Other than these circumstances, you must have approval in advance (“prior authorization”) from the plan to get coverage of a prescription from an out-of-network provider.

If you pay “out-of-pocket” for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 7, Section 2.1 tells how to ask us to pay our share of the cost for the drug.

## SECTION 3 Fill your prescription at a network pharmacy or through the plan's mail-order service

### Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are covered on the plan's Drug List.

### Section 3.2 Finding network pharmacies

#### How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Provider/Pharmacy Directory, visit our website ([www.molinamedicare.com](http://www.molinamedicare.com)), or call Member Services (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

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### What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the back cover of this booklet) or use the Provider/Pharmacy Directory. You can also find information on our website at [www.molinamedicare.com](http://www.molinamedicare.com).

### What if you need 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. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are 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 locate a specialized pharmacy, look in your Provider / Pharmacy Directory or call Member Services.

### Section 3.3 Using the plan's mail-order services

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

Our plan's mail-order service requires you to order **at least an 84-day supply of the drug and no more than a 90-day supply**.

To get order forms and information about filling your prescriptions by mail please call Member Services.

Usually a mail-order pharmacy order will get to you in no more than 14 days. Please call Member Services for help in receiving a temporary supply of your prescription at 1-800-665-0898. Monday through Sunday, 8:00 AM to 8:00 PM local time. TTY/TDD users please call 1-800-346-4128.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

### Section 3.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of “mail-order” drugs on our plan's Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. The drugs available through our plan's mail-order service are marked as “**mail-order**” drugs in our Drug List. The drugs that are not available through the plan's mail-order service are marked with NM indicating non-mail order in our Drug List. Our plan's mail-order service requires you to order at least an 84-day supply of the drug and no more than a 90-day supply. See Section 3.3 for more information about using our mail-order services.

### Section 3.5 When can you use a pharmacy that is not in the plan's network?

#### Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- 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 30 day supply unless the prescription is written for less

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

#### How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

## SECTION 4 Your drugs need to be on the plan's “Drug List”

### Section 4.1 The “Drug List” tells which Part D drugs are covered

The plan has a “List of Covered Drugs (Formulary).” In this Evidence of Coverage, **we call it the “Drug List” for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

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We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

### The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

### What is not on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.
- Additionally, Medicaid-covered drugs are not listed on the Drug List. You should contact your State Medicaid office for more information on Medicaid-covered drugs (the contact information is listed in Chapter 2 Section 6).

### Section 4.2 There are four (4) "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 – Generic (Lowest cost share)
- Tier 2 – Preferred Brand
- Tier 3 – Non-Preferred Brand
- Tier 4 – Specialty (Highest cost share)

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (What you pay for your Part D prescription drugs).

### Section 4.3 How can you find out if a specific drug is on the Drug List?

You have three (3) ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website ([www.molinamedicare.com](http://www.molinamedicare.com)). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the back cover of this booklet.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

## SECTION 5 There are restrictions on coverage for some drugs

### Section 5.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

### Section 5.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

- Quantity limits – We may quantity restrict the prescription based on safety and efficiency
- Prior authorization requirements are used by the plan to ensure the drug is being used appropriately to treat your disease.
- Step Therapy – We may require you try other medications before you will receive the requested medication.

### Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

### Trying a different drug first

**This requirement** encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

### Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

### Section 5.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the back cover of this booklet) or check our website ([www.molinamedicare.com](http://www.molinamedicare.com)).

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

## SECTION 6 What if one of your drugs is not covered in the way you'd like it to be covered?

### Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of four (4) different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 6.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

### Section 6.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

### You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

#### 1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

#### 2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**  
We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to the plan and aren't in a long-term care facility:**  
We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to the plan and reside in a long-term care facility:**  
We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**  
We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

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- If you are a new resident of a LTC facility and have been enrolled in our Plan for more than 90 days and need a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the member pursues a formulary exception. Exceptions are available in situations where you experience a change in the level of care you are receiving that also requires you to transition from one facility or treatment center to another. In such circumstances, you would be eligible for a temporary, one-time fill exception even if you are outside of the first 90 days as a member of the plan. Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access.

To ask for a temporary supply, call Member Services (phone numbers are on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

### **You can change to another drug**

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### **You can ask for an exception**

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

### **Section 6.3 What can you do if your drug is in a cost-sharing tier you think is too high?**

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

### **You can change to another drug**

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

### You can ask for an exception

For drugs in tier 3, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in tiers 2 – 4.

## SECTION 7 What if your coverage changes for one of your drugs?

### Section 7.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

### Section 7.2 What happens if coverage changes for a drug you are taking?

#### How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

#### Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

## SECTION 8 What types of drugs are not covered by the plan?

### Section 8.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."
- Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Medicaid-covered drugs are not listed on the Drug List. You should contact your State Medicaid office for more information on Medicaid-covered drugs (the contact information is listed in Chapter 2, Section 6).
- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

## SECTION 9 Show your plan membership card when you fill a prescription

### Section 9.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for our share of the costs of your covered prescription drug. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

### Section 9.2 What if you don't have your membership card with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

## SECTION 10 Part D drug coverage in special situations

### Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

### Section 10.2 What if you're a resident in a long-term care facility?

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

Check your Provider/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, please contact Member Services.

## Chapter 5.

# Using the plan's coverage for your Part D prescription drugs

### What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

## SECTION 11 Programs on drug safety and managing medications

### Section 11.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

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

### Section 11.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back cover of this booklet)

## Chapter 6. What you pay for your Part D prescription drugs

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<b>SECTION 1</b>	<b>Introduction .....</b>	<b>78</b>
Section 1.1	Use this chapter together with other materials that explain your drug coverage .....	78
<b>SECTION 2</b>	<b>What you pay for a drug depends on which “drug payment stage” you are in when you get the drug .....</b>	<b>79</b>
Section 2.1	What are the drug payment stages for Molina Medicare Options Plus HMO SNP members?.....	79
<b>SECTION 3</b>	<b>We send you reports that explain payments for your drugs and which payment stage you are in .....</b>	<b>79</b>
Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”) .....	79
Section 3.2	Help us keep our information about your drug payments up to date .....	80
<b>SECTION 4</b>	<b>During the Deductible Stage, you pay the full cost of your tiers 2 – 4 drugs.....</b>	<b>81</b>
Section 4.1	You stay in the Deductible Stage until you have paid \$320 for your tiers 2 – 4 drugs...	81
<b>SECTION 5</b>	<b>During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share .....</b>	<b>81</b>
Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription ...	81
Section 5.2	A table that shows your costs for a one-month supply of a drug .....	82
Section 5.3	A table that shows your costs for a long-term ( up to a 90-day) supply of a drug .....	83
Section 5.4	You stay in the Initial Coverage Stage until your drug costs for the year reach \$2,930.	83
Section 5.5	How Medicare calculates your out-of-pocket costs for prescription drugs .....	84

## Chapter 6. What you pay for your Part D prescription drugs

---

<b>SECTION 6</b>	<b>During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 86% of the costs of generic drugs .....</b>	<b>85</b>
Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700.....	85
Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs .....	86
<b>SECTION 7</b>	<b>During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs.....</b>	<b>87</b>
Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year .....	87
<b>SECTION 8</b>	<b>What you pay for vaccinations covered by Part D depends on how and where you get them .....</b>	<b>88</b>
Section 8.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot.....	88
Section 8.2	You may want to call us at Member Services before you get a vaccination.....	89

## Chapter 6. What you pay for your Part D prescription drugs



### How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

## SECTION 1 Introduction

### Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid. To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four (4) “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at [www.molinamedicare.com](http://www.molinamedicare.com). The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s Provider/Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Provider/Pharmacy Directory has a list of pharmacies in the plan’s network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

## Chapter 6. What you pay for your Part D prescription drugs

### SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug

#### Section 2.1 What are the drug payment stages for Molina Medicare Options HMO members?

As shown in the table below, there are “drug payment stages” for your Medicare Part D prescription drug coverage under Molina Medicare Options Plus HMO SNP. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>If you receive Extra Help to pay your prescription drugs, this payment stage does not apply to you.</p> <p>During this stage, you pay the full cost of your tiers 2- 4 drugs.</p> <p>You stay in this stage until you have paid \$320 for your tiers 2 - 4 drugs (\$320 is the amount of your tiers 2-4 deductible).</p> <p><i>(Details are in Section 4 of this chapter.)</i></p>	<p>During this stage, the plan pays its share of the cost of your tiers 2 – 4 drugs and <b>you pay your share of the cost.</b></p> <p>After you (or others on your behalf) have met your tiers 2- 4 deductible, the plans pays its share of the costs of your tiers 2 - 4 drugs and you pay your share.</p> <p>You stay in this stage until your year-to-date “<b>total drug costs</b>” (your payments plus any Part D plan’s payments) total \$2,930</p> <p><i>(Details are in Section 5 of this chapter.)</i></p>	<p>During this stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs.</p> <p>You stay in this stage until your year-to-date “<b>out-of-pocket costs</b>” (your payments) reach a total of \$4,700. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p><i>(Details are in Section 6 of this chapter.)</i></p>	<p>During this stage, <b>the plan will pay most of the costs</b> of your drugs for the rest of the calendar year (through December 31, 2012).</p> <p><i>(Details are in Section 7 of this chapter.)</i></p>

### SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

#### Section 3.1 We send you a monthly report called the “Explanation of Benefits” (the “EOB”)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

## Chapter 6.

# What you pay for your Part D prescription drugs

Our plan will prepare a written report called the Explanation of Benefits (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

### Section 3.2 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an Explanation of Benefits (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

## Chapter 6. What you pay for your Part D prescription drugs

### SECTION 4 During the Deductible Stage, you pay the full cost of your tiers 2 – 4 drugs

#### Section 4.1 You stay in the Deductible Stage until you have paid \$320 for your tiers 2 – 4 drugs

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive Extra Help, this payment stage does not apply to you.

If you do not receive Extra Help, the Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of \$320 on tiers 2 – 4 drugs. **You must pay the full cost of your tiers 2 – 4 drugs** until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.

- Your **“full cost”** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **“deductible”** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid \$320 for your tiers 2 - 4 drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

### SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

#### Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

#### The plan has four (4) cost-sharing tiers

Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 – Generic (Lowest cost share)
- Tier 2 – Preferred Brand
- Tier 3 – Non-Preferred Brand
- Tier 4 – Specialty (Highest cost share)

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

#### Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

## Chapter 6.

# What you pay for your Part D prescription drugs

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's Provider/Pharmacy Directory.

### Section 5.2 A table that shows your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 3.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

**Your share of the cost when you get a one-month supply (or less) of a covered Part D prescription drug from:**

	<b>Network pharmacy</b>  (up to a 31-day supply)	<b>The plan's mail-order service</b>  (up to a 90-day supply)	<b>Network long-term care pharmacy</b>  (up to a 31-day supply)	<b>Out-of-network pharmacy</b> (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 31-day supply)
<b>Cost-Sharing Tier 1</b> (Generic Brand)	\$0 or \$1.10 or \$2.60 copay	\$0 or \$1.10 or \$2.60 copay	\$0 or \$1.10 or \$2.60 copay	\$0 or \$1.10 or \$2.60 copay
<b>Cost-Sharing Tier 2</b> (Preferred Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay
<b>Cost-Sharing Tier 3</b> (Non-Preferred Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50	\$0 or \$3.30 or \$6.50 copay
<b>Cost-Sharing Tier 4</b> (Specialty Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 copay

## Chapter 6.

# What you pay for your Part D prescription drugs

### Section 5.3 A table that shows your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

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

	<b>Network pharmacy</b> (up to a 90-day supply)	<b>The plan’s mail-order service</b> (up to a 90-day supply)
<b>Cost-Sharing Tier 1</b> (Generic Brand)	\$0 or \$1.10 or \$2.60 copay	\$0 or \$1.10 or \$2.60 Copay
<b>Cost-Sharing Tier 2</b> (Preferred Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 Copay
<b>Cost-Sharing Tier 3</b> (Non-Preferred Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 Copay
<b>Cost-Sharing Tier 4</b> (Specialty Brand)	\$0 or \$3.30 or \$6.50 copay	\$0 or \$3.30 or \$6.50 Copay

### Section 5.4 You stay in the Initial Coverage Stage until your drug costs for the year reach \$2,930

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$2,930 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The \$320 you paid when you were in the Deductible Stage.
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

Section 4.5 tells you more about what counts toward your out-of-pocket costs.

The Explanation of Benefits (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2,930 limit in a year.

We will let you know if you reach this \$2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

## Chapter 6.

# What you pay for your Part D prescription drugs

### Section 5.5 How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments **are included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - o The Deductible Stage.
  - o The Initial Coverage Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

#### It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

#### Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,700 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

## Chapter 6. What you pay for your Part D prescription drugs

These payments are **not included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Drugs covered by Medicaid only.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

**Reminder:** If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the back cover of this booklet).

### How can you keep track of your out-of-pocket total?

- **We will help you.** The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

## **SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 86% of the costs of generic drugs**

### **Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,700**

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more 86% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (14%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 86% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2012, that amount is \$4,700.

## Chapter 6. What you pay for your Part D prescription drugs

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

### Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments **are included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - o The Deductible Stage.
  - o The Initial Coverage Stage.
  - o The Coverage Gap Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

#### It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

#### Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$ 4,700 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

## Chapter 6. What you pay for your Part D prescription drugs

These payments are **not included** in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

**Reminder:** If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the back cover of this booklet).

### How can you keep track of your out-of-pocket total?

- **We will help you.** The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

## SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

### Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:
  - –either – coinsurance of 5% of the cost of the drug
  - –or – \$2.60 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.50 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

## Chapter 6. What you pay for your Part D prescription drugs

### SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

#### Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

#### What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, Benefits Chart (what is covered).
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s List of Covered Drugs (Formulary).
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay nothing.

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself
- Our plan will pay for the cost of giving you the vaccination shot.

## Chapter 6.

# What you pay for your Part D prescription drugs

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Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay you back for our share of the cost by using the procedures that are described in Chapter 7 of this booklet (Asking us to pay our share of a bill you have received for covered medical services or drugs).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay you back for our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.
- Additionally, based upon your level of Medicaid eligibility you may receive assistance with some or all cost sharing amounts.

### **Section 8.2 You may want to call us at Member Services before you get a vaccination**

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to ask us to pay you back for our share of the cost.
- Additionally, based upon your level of Medicaid eligibility you may receive assistance with some or all cost sharing amounts.

## **Chapter 7.**

### **Asking us to pay a bill you have received for covered medical services or drugs**

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<b>SECTION 1</b>	<b>Situations in which you should ask us to pay for your covered services or drugs.....</b>	<b>91</b>
Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment.....	91
<b>SECTION 2</b>	<b>How to ask us to pay you back or to pay a bill you have received.....</b>	<b>92</b>
Section 2.1	How and where to send us your request for payment.....	92
<b>SECTION 3</b>	<b>We will consider your request for payment and say yes or no .....</b>	<b>93</b>
Section 3.1	We check to see whether we should cover the service or drug .....	93
Section 3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal .....	93
<b>SECTION 4</b>	<b>Other situations in which you should save your receipts and send copies to us .....</b>	<b>93</b>
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs .....	93

## Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

### **SECTION 1 Situations in which you should ask us to pay for your covered services or drugs**

#### **Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment**

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

#### **1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network**

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid for the service, we will pay you back.

#### **2. When a network provider sends you a bill you think you should not pay**

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services

#### **3. If you are retroactively enrolled in our plan.**

Sometimes a person’s enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement.

- Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

## Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

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### 4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 3.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back .

### 5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back .

### 6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

## SECTION 2 How to ask us to pay you back or to pay a bill you have received

### Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

Molina Medicare  
Attention: Member Services  
P.O. Box 8542  
Midvale, UT 84047

Please be sure to contact Member Services if you have any questions. If you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

## Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

### **SECTION 3 We will consider your request for payment and say yes or no**

#### **Section 3.1 We check to see whether we should cover the service or drug**

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

#### **Section 3.2 If we tell you that we will not pay for the medical care or drug, you can make an appeal**

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

### **SECTION 4 Other situations in which you should save your receipts and send copies to us**

#### **Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs**

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

## Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

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### **When you get a drug through a patient assistance program offered by a drug manufacturer**

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

## **Chapter 8.**

# **Your rights and responsibilities**

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<b>SECTION 1</b>	<b>Our plan must honor your rights as a member of the plan .....</b>	<b>96</b>
Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.) .....	96
Section 1.2	We must treat you with fairness and respect at all times.....	96
Section 1.3	We must ensure that you get timely access to your covered services and drugs .....	97
Section 1.4	We must protect the privacy of your personal health information .....	97
Section 1.5	We must give you information about the plan, its network of providers, and your covered services.....	98
Section 1.6	We must support your right to make decisions about your care.....	99
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made .....	101
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected? .....	101
Section 1.9	How to get more information about your rights.....	101
<b>SECTION 2</b>	<b>You have some responsibilities as a member of the plan .....</b>	<b>102</b>
Section 2.1	What are your responsibilities? .....	102

## Chapter 8. Your rights and responsibilities

### SECTION 1 Our plan must honor your rights as a member of the plan

#### Section 1.1 We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY/TDD users call 1-877-486-2048.

#### Section 1.1 Debemos proporcionar información de una manera que sea útil para usted (en otros idiomas además del inglés, en sistema Braille, en letra grande, u otros formatos alternativos, etc.)

Para obtener información de nosotros de una manera que le sea útil, favor de llamar al departamento de Servicios para Miembros (los números telefónicos se encuentran en la portada trasera de este folleto).

Nuestro plan tiene a personas que brindan servicios gratuitos de intérprete de idiomas, los cuales están disponibles a contestar las preguntas de los miembros que no hablan el idioma inglés. Si usted necesita, también le podemos proporcionar la información en el sistema Braille, en letra grande, u otros formatos alternativos. Si usted es elegible para Medicare por causa de una discapacidad, se nos requiere que le proporcionemos información acerca de los beneficios del plan que sean accesibles y apropiados para usted.

Si usted tiene cualquier problema para obtener la información de nuestro plan a causa de problemas relacionados con el idioma o por una discapacidad, favor de llamar a Medicare al 1-800-MEDICARE (1-800-633-4227), 24 horas al día, 7 días a la semana, y dígales que quiere presentar una queja. Para los usuarios de TTY/TDD llamar al: 1-877-486-2048.

#### Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY/TDD 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

## Chapter 8.

# Your rights and responsibilities

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### Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

### Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

### How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

### You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

## Chapter 8.

# Your rights and responsibilities

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If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the back cover of this booklet).

### Section 1.5 We must give you information about the plan, its network of providers, and your covered services

We provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers and pharmacies in the plan's network, see the Provider/Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at [www.molinamedicare.com](http://www.molinamedicare.com).
- **Information about your coverage and rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

## Chapter 8. Your rights and responsibilities

- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

### Section 1.6 We must support your right to make decisions about your care

#### You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

#### You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, if you want to, you can:

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

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

**Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are on the back cover of this booklet).

## Chapter 8. Your rights and responsibilities

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The forms are also available through a link to Caring Connections on the Molina Medicare website by following these steps:

Go to [www.molinamedicare.com](http://www.molinamedicare.com).

- Go to “Select State”. Select the state you live in, and click “Go”.
- Click on “quality” in the top/middle of the page.
- Click on “rights & responsibilities” under quality.
- Click on “advance directives” under rights & responsibilities.
  - Click on “Download your state’s Advance Directives Form”.
  - **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
  - **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with:

Medical Board of California for complaints regarding physicians contact

Central Complaint Unit  
2005 Evergreen Street, Suite 1200  
Sacramento, CA 95815  
(800) 633-2322  
(916) 263-2382 or (916) 263-2424

For complaints regarding hospitals/healthcare facilities contact:

California Department of Public Health Licensing & Certification  
(800) 236-9747  
(916) 552-8700

## Chapter 8. Your rights and responsibilities

### Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the back cover of this booklet).

### Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

#### If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

#### Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## Chapter 8.

# Your rights and responsibilities

## SECTION 2 You have some responsibilities as a member of the plan

### Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your Medicaid card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For most Molina Medicare Options Plus HMO SNP members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

## Chapter 8. Your rights and responsibilities

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- If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call member services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

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### BACKGROUND

<b>SECTION 1</b>	<b>Introduction.....</b>	<b>107</b>
Section 1.1	What to do if you have a problem or concern .....	107
Section 1.2	What about the legal terms? .....	107
<b>SECTION 2</b>	<b>You can get help from government organizations that are not connected with us.....</b>	<b>107</b>
Section 2.1	Where to get more information and personalized assistance.....	107
<b>SECTION 3</b>	<b>To deal with your problem, which process should you use?.....</b>	<b>109</b>
Section 3.1	Should you use the process for Medicare benefits or Medicaid benefits?.....	109

### PROBLEMS ABOUT YOUR MEDICARE BENEFITS

<b>SECTION 4</b>	<b>Handling problems about your <u>Medicare</u> benefits.....</b>	<b>110</b>
Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? .....	110
<b>SECTION 5</b>	<b>A guide to the basics of coverage decisions and appeals.....</b>	<b>110</b>
Section 5.1	Asking for coverage decisions and making appeals: the big picture.....	110
Section 5.2	How to get help when you are asking for a coverage decision or making an appeal.....	111
Section 5.3	Which section of this chapter gives the details for <u>your</u> situation?.....	112
<b>SECTION 6</b>	<b>Your medical care: How to ask for a coverage decision or make an appeal .....</b>	<b>112</b>
Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.....	112
Section 6.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want) .....	113
Section 6.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan) .....	115
Section 6.4	Step-by-step: How to make a Level 2 Appeal .....	117
Section 6.5	What if you are asking us to pay you for our share of a bill you have received for medical care? .....	119

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

---

<b>SECTION 7</b>	<b>Your Part D prescription drugs: How to ask for a coverage decision or make an appeal .....</b>	<b>120</b>
Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug.....	120
Section 7.2	What is an exception? .....	121
Section 7.3	Important things to know about asking for exceptions .....	122
Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception.....	122
Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan).....	124
Section 7.6	Step-by-step: How to make a Level 2 Appeal .....	126
<b>SECTION 8</b>	<b>How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon .....</b>	<b>128</b>
Section 8.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights.....	128
Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date ..	129
Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date ..	131
Section 8.4	What if you miss the deadline for making your Level 1 Appeal?.....	131
<b>SECTION 9</b>	<b>How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....</b>	<b>133</b>
Section 9.1	This section is about three services <u>only</u> : Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services .....	133
Section 9.2	We will tell you in advance when your coverage will be ending .....	134
Section 9.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	134
Section 9.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	136
Section 9.5	What if you miss the deadline for making your Level 1 Appeal?.....	137
<b>SECTION 10</b>	<b>Taking your appeal to Level 3 and beyond .....</b>	<b>139</b>
Section 10.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals .....	139
Section 10.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	140

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

---

**SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns .....142**

Section 11.1 What kinds of problems are handled by the complaint process? ..... 142

Section 11.2 The formal name for “making a complaint” is “filing a grievance” ..... 143

Section 11.3 Step-by-step: Making a complaint..... 143

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization ..... 144

**PROBLEMS ABOUT YOUR MEDICAID BENEFITS**

**SECTION 12 Handling problems about your Medicaid benefits.....145**

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

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### **BACKGROUND**

#### **SECTION 1 Introduction**

##### **Section 1.1 What to do if you have a problem or concern**

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)
2. The type of problem you are having:
  - For some types of problems, you need to use the **process for coverage decisions and making appeals**.
  - For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

##### **Section 1.2 What about the legal terms?**

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

#### **SECTION 2 You can get help from government organizations that are not connected with us**

##### **Section 2.1 Where to get more information and personalized assistance**

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

## Chapter 9.

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

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### Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

### You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

### You can get help and information from Medicaid

If you have questions about the assistance you get from Medicaid, contact California Department of Health Care Services' Medi-Cal Program.

<b>California Department of Health Care Services' Medi-Cal Program</b>	
<b>CALL</b>	Sacramento County 1-916-874-2256
<b>TTY</b>	711
<b>WRITE</b>	California Department of Health Care Services P.O. Box 997413 Sacramento, CA 95899-7413

The Medi-Cal Managed Care Office of the Ombudsman helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

<b>Medi-Cal Managed Care Office of the Ombudsman</b>	
<b>CALL</b>	1-888-452-8609
<b>WEBSITE</b>	<a href="mailto:MMCDOmbudsmanOffice@dhcs.ca.gov">MMCDOmbudsmanOffice@dhcs.ca.gov</a>

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

The WISE & Healthy Aging Long-Term Care Ombudsman Program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<b>WISE &amp; Healthy Aging Long-Term Care Ombudsman Program</b>	
<b>CALL</b>	(310) 394-9871 (310) 393-3618 (800) 334-9473
<b>TTY/TDD</b>	711
<b>WRITE</b>	WISE & Healthy Aging Headquarters 1527 4th St., 2nd Floor Santa Monica, CA 90401
<b>WEBSITE</b>	<a href="http://www.aging.ca.gov/programs/ombudsman.asp">www.aging.ca.gov/programs/ombudsman.asp</a>

### **SECTION 3 To deal with your problem, which process should you use?**

#### **Section 3.1 Should you use the process for Medicare benefits or Medicaid benefits?**

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

#### **Is your problem about Medicare benefits or Medicaid benefits?**

(If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services.)

My problem is about **Medicare** benefits.

Go to the next section of this chapter, **Section 4, “Handling problems about Medicare your benefits.”**

My problem is about **Medicaid** benefits.

Skip ahead to **Section 12** of this chapter, **“Handling problems about your Medicaid benefits.”**

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

### **PROBLEMS ABOUT YOUR MEDICARE BENEFITS**

#### **SECTION 4 Handling problems about your Medicare benefits**

##### **Section 4.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?**

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

#### **Is your problem or concern about your benefits or coverage?**

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

**YES** My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and making appeals.”**

**NO** My problem is not about benefits or coverage. Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

#### **SECTION 5 A guide to the basics of coverage decisions and appeals**

##### **Section 5.1 Asking for coverage decisions and making appeals: the big picture**

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

#### **Asking for coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

## Chapter 9.

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

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### Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

### Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

## Chapter 9.

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

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### Section 5.3 Which section of this chapter gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Out-patient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

## SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

### Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: Benefits Chart (what is covered). To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

## Chapter 9.

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

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
  - Chapter 9, Section 8: How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.
  - Chapter 9, Section 9: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

Which of these situations are you in?	
<b>If you are in this situation:</b>	<b>This is what you can do:</b>
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you.  Go to the next section of this chapter, <b>Section 6.2</b> .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an <b>appeal</b> . (This means you are asking us to reconsider.)  Skip ahead to <b>Section 6.3</b> of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill.  Skip ahead to <b>Section 6.5</b> of this chapter.

#### Section 6.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

**Step 1: You ask our plan to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a “**fast decision**.”

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your medical care.

Generally we use the standard deadlines for giving you our decision

#### Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination**.”

A “fast decision” is called an “**expedited determination**.”

## Chapter 9.

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

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When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A **standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

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

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

### **Step 2: We consider your request for medical care coverage and give you our answer.**

Deadlines for a “fast” coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours.**
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

## Chapter 9.

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

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- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

### Deadlines for a “standard” coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

### **Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

## **Section 6.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)**

**Step 1: You contact us and make your appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

### What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, How to contact us when you are making an appeal about your medical care.
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**

### Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”

## Chapter 9.

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

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- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

### Legal Terms

A “fast decision” is also called an **“expedited reconsideration.”**

#### **Step 2: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

#### **Deadlines for a “fast” appeal**

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

## Chapter 9.

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

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- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

### Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

### **Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

## Section 6.4 Step-by-step: How to make a Level 2 Appeal

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

### **Step 1: The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

### Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

## Chapter 9.

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

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- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a **“fast” appeal** at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

If you had a “standard” appeal at Level 1, you will also have a **“standard” appeal** at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

### **Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

### **Step 3: 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 of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Chapter 9.

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

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### Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

#### Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: Benefits Chart (what is covered)). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: Using the plan's coverage for your medical services).

#### We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.)

#### What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

**To make this appeal, follow the process for appeals that we describe in part 5.3 of this section.** Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

## Chapter 9.

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

### SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

#### Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s List of Covered Drugs (Formulary) and the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 (Using our plan’s coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

#### Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
  - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

#### Legal Terms

An initial coverage decision about your Part D drugs is called a “**coverage determination.**”

## Chapter 9.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

<b>Which of these situations are you in?</b>			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with <b>Section 7.2</b> of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to <b>Section 7.5</b> of this chapter.</p>

### Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, 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 will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** (We call it the “Drug List” for short.)
  - You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)
2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 5).
  - The extra rules and restrictions on coverage for certain drugs include:
    - Being required to use the generic version of a drug instead of the brand name drug.
    - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)

### Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “**formulary exception.**”

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

Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “**tiering exception.**”

## Chapter 9.

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

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- Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of four (4) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.
- If your drug is in of the non-preferred or 3<sup>rd</sup> tier you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred or 2<sup>nd</sup> tier. This would lower your share of the cost for the drug.
  - You cannot ask us to change the cost-sharing tier for any drug in the specialty tier or 4<sup>th</sup> tier.

### Section 7.3 Important things to know about asking for exceptions

#### Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

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

#### We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

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

### Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

**Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a “fast decision.” You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the section called, Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

## Chapter 9.

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

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- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: Asking us to pay a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

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

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.

### Legal Terms

A “fast decision” is called an **“expedited coverage determination.”**

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our 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 the process for making complaints, see Section 11 of this chapter.)

### **Step 2: We consider your request and we give you our answer.**

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.

## Chapter 9.

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

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- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

## Chapter 9.

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

### Section 7.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

**Step 1: You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, How to contact our plan when you are making an appeal about your Part D prescription drugs.
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 7.4 of this chapter.

**Step 2: Our plan considers your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

#### Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “**redetermination.**”

#### Legal Terms

A “fast appeal” is also called an “**expedited redetermination.**”

## Chapter 9.

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

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- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### **Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

### **Section 7.6 Step-by-step: How to make a Level 2 Appeal**

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

#### **Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** You have a right to give the Independent Review Organization additional information to support your appeal.

#### **Legal Terms**

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

## Chapter 9.

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

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### **Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

#### Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

#### Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

### **What if the review organization says no to your appeal?**

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

### **Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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 of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Chapter 9.

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

### SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: Benefits Chart (what is covered).

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

#### Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

**2. You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

#### Legal Terms

The written notice from Medicare tells you how you can “request an immediate review.” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

## Chapter 9.

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

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3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
  - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at [http://www.cms.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp).

### Section 8.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.**

It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (An Important Message from Medicare About Your Rights) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.

#### Legal Terms

A “fast review” is also called an **“immediate review.”**

## Chapter 9.

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

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- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

What happens if the answer is yes?

- If the review organization says yes to your appeal, **we must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

### Legal Terms

A “**fast review**” is also called an “**immediate review**” or an “**expedited review**.”

### Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at <http://www.cms.hhs.gov/BNI/>

## Chapter 9.

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

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### Section 8.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

#### **Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

#### **Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

#### **Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

#### **Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

### Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

#### **You can appeal to us instead**

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

## Chapter 9.

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

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### Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

#### **Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, How to contact our plan when you are making an appeal about your medical care.
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

#### Legal Terms

A “fast” review (or “fast appeal”) is also called an “expedited appeal”.

#### **Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

#### **Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

#### **Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

### Step-by-Step: How to make a Level 2 Alternate Appeal

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

#### **Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

#### Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

## Chapter 9.

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

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**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

**Step 3: If the Independent Review Organization turns down your appeal, 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 of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## **SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

### **Section 9.1 This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

This section is about the following types of care only:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, Definitions of important words.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, Definitions of important words.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: Benefits Chart (what is covered).

## Chapter 9.

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

### Section 9.2 We will tell you in advance when your coverage will be ending

- 1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.
- 2. You must sign the written notice to show that you received it.**
  - You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it's time to stop getting the care.

#### Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

### Section 9.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**

**Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.**

## Chapter 9.

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

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What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

### **Step 2: The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

### **Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

### **Legal Terms**

This notice explanation is called the “**Detailed Explanation of Non-Coverage.**”

## Chapter 9.

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

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### **Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- This first appeal you make is “Level 1” of the appeals process. If reviewers say no to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

### **Section 9.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time**

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

#### **Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

#### **Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

#### **Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

#### **Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

## Chapter 9.

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

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### Section 9.5 What if you miss the deadline for making your Level 1 Appeal

#### You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

#### Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

#### **Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact our plan when you are making an appeal about your medical care.
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

#### Legal Terms

A “fast” review (or “fast appeal”) is also called an “expedited appeal”.

#### **Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

#### **Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

#### **Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

## Chapter 9.

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

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### Step-by-Step: How to make a Level 2 Alternate Appeal

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

#### **Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

#### **Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

#### **Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

### Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity**.” It is sometimes called the “**IRE**.”

## Chapter 9.

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

## SECTION 10 Taking your appeal to Level 3 and beyond

### Section 10.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<b>Level 3 Appeal</b>	A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
  - If we decide to appeal the decision, we will 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 the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

<b>Level 4 Appeal</b>	The <b>Medicare Appeals Council</b> will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council’s decision.
  - If we decide to appeal the decision, we will let you know in writing.

## Chapter 9.

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

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- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

### Level 5 Appeal

A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

## Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

### Level 3 Appeal

A **judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

## Chapter 9.

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

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<b>Level 4 Appeal</b>	The <b>Medicare Appeals Council</b> will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.
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- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

<b>Level 5 Appeal</b>	A judge at the <b>Federal District Court</b> will review your appeal.
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- This is the last step of the appeals process.

## Chapter 9.

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

### SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

#### Section 11.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

#### If you have any of these kinds of problems, you can “make a complaint”

##### Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

##### Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

##### Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

##### Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals?  
Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

##### Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

##### Information you get from our plan

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of possible reasons for making a complaint*

## Chapter 9.

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

#### Possible complaints (continued)

**These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals**

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

#### Section 11.2 The formal name for “making a complaint” is “filing a grievance”

##### Legal Terms

- What this section calls a “complaint” is also called a “grievance.”
- Another term for “making a complaint” is “filing a grievance.”
- Another way to say “using the process for complaints” is “using the process for filing a grievance.”

#### Section 11.3 Step-by-step: Making a complaint

##### **Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. You can reach Member Services at 1-800-665-0898, TTY/TDD 1-800-346-4128. Hours of Operation are Monday through Sunday from 8:00 AM to 8:00 PM, local time.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, put your complaint in writing, we will respond to your complaint in writing.
- We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Member Grievance Process.**

## Chapter 9.

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

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We will respond to all quality of care grievances in writing, regardless of how the grievance was filed no later than (30) days, unless additional information is needed.

You, or your representative, are entitled to file an expedited grievance whenever Molina asks for an extension relating to an organization's determination reconsideration, or when we refuse to expedite a request for an organization determination or reconsideration. Molina will respond to these grievances within (24) hours after receipt.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you an answer within 24 hours.

### Legal Terms

What this section calls a “fast complaint” is also called an “expedited grievance.”

#### Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

### Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

## Chapter 9.

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

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- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

## PROBLEMS ABOUT YOUR MEDICAID BENEFITS

### SECTION 12 Handling problems about your Medicaid benefits

If you have applied for, have received, or are currently receiving benefits or services from Medi-Cal (Medicaid) and you have a complaint about how your Medi-Cal covered benefits or services are being handled or were handled, or if your Medi-Cal covered services have been denied or modified and you want to make an appeal, you need to use the process for making Medi-Cal appeals and complaints.

1. How to ask for an appeal or make a complaint about your Medi-Cal (Medicaid) covered benefits.

You can file an appeal or a complaint about your benefits covered by Medi-Cal (Medicaid). Here's how:

- If you receive your Medi-Cal (Medicaid) benefits from the Molina Medi-Cal managed care plan in Riverside, Sacramento, San Bernardino or San Diego counties, refer to your Molina Medi-Cal Member Handbook for information on how to file a complaint, including timeframes on when you must file your complaint. You can also write or call Molina Medi-Cal Member Services at:

Molina Medi-Cal Member Services Department

200 OceanGate Suite 100

Long Beach, CA 90802

Phone: Molina Member Services at 1-800-665-0898, TTY/TDD user please call 1-800-346-4128 these lines are available 24 hours a day, seven days a week. Calls to these numbers are free.

- If you receive your Medi-Cal (Medicaid) benefits from the Health Net Medi-Cal managed care plan in Los Angeles county, refer to your Health Net Medi-Cal Member Handbook for information on how to file a complaint, including timeframes on when you must file your complaint. You can also write or call Health Net Medi-Cal Member Services at:

HealthNet Medi-Cal Member Services Department

21271 Burbank Blvd., C-5

Woodland Hills, CA 91367-6607

Phone: Health Net Member Services at 1-800-675-6110 (TTY/TDD users 1-800-431-0964), 24 hours a day, seven days a week. Calls to these numbers are free.

- Or you may call the California Department of Health Care Services Ombudsman at 1-888-452-8609 (TTY/TDD users please use the National Relay Service – 711).

2. How to ask for an appeal or make a complaint about your Medi-Cal (Medicaid) covered benefits.

Medi-Cal (Medicaid) beneficiaries have a right to ask for a State Fair Hearing (Med-Cal State Hearing) at any time, regardless of whether complaint has been submitted, and at any time during the complaint process. A hearing is an administrative procedure at which you can present your concern directly to the State of California. The hearing can only make a ruling on the denial, modification or termination of a covered benefit. You must ask for a State Hearing within 90 days of the date of the decision or action that you are unhappy about.

## Chapter 9.

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

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If you decide to request a hearing, you may represent yourself at the hearing or another person, such as an attorney, friend, relative, or any person you choose may represent you. DSS can help you obtain a Legal Aid lawyer, free of charge, to help you with your hearing.

To ask for a State Hearing, call or write to the Department of Social Services:

California Department of Social Services  
State Hearing Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430  
1-800-952-5253 Calls to this number are free.  
TTY/TDD please use 711.

## Chapter 10. Ending your membership in the plan

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<b>SECTION 1</b>	<b>Introduction .....</b>	<b>148</b>
Section 1.1	This chapter focuses on ending your membership in our plan.....	148
<b>SECTION 2</b>	<b>When can you end your membership in our plan?.....</b>	<b>148</b>
Section 2.1	You can end your membership at any time.....	148
Section 2.2	Where can you get more information about when you can end your membership?....	149
<b>SECTION 3</b>	<b>How do you end your membership in our plan?.....</b>	<b>149</b>
Section 3.1	Usually, you end your membership by enrolling in another plan .....	149
<b>SECTION 4</b>	<b>Until your membership ends, you must keep getting your medical services and drugs through our plan.....</b>	<b>150</b>
Section 4.1	Until your membership ends, you are still a member of our plan.....	150
<b>SECTION 5</b>	<b>Molina Medicare Options Plus HMO SNP must end your membership in the plan in certain situations .....</b>	<b>151</b>
Section 5.1	When must we end your membership in the plan?.....	151
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	152
Section 5.3	You have the right to make a complaint if we end your membership in our plan .....	152

## Chapter 10. Ending your membership in the plan

### SECTION 1 Introduction

#### Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Molina Medicare Options Plus HMO SNP may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

### SECTION 2 When can you end your membership in our plan?

#### Section 2.1 You can end your membership at any time

You can end your membership in Molina Medicare Options Plus HMO SNP at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medicaid, **you can end your membership in Molina Medicare Options Plus HMO SNP at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.
- If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

## Chapter 10. Ending your membership in the plan

### Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the **Medicare & You 2012 Handbook**.
  - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### SECTION 3 How do you end your membership in our plan?

#### Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription 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 if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

## Chapter 10. Ending your membership in the plan

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> <li>• Another Medicare health plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare health plan.</li> </ul> <p>You will automatically be disenrolled from Molina Medicare Options Plus HMO SNP when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> <li>• Original Medicare with a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare prescription drug plan.</li> </ul> <p>You will automatically be disenrolled from Molina Medicare Options Plus HMO SNP when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> <li>• Original Medicare without a separate Medicare prescription drug plan.                             <ul style="list-style-type: none"> <li>o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Send us a written request to disenroll.</b> Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).</li> <li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li> <li>• You will be disenrolled from Molina Medicare Options Plus HMO SNP when your coverage in Original Medicare begins.</li> </ul>

### SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

#### Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Molina Medicare Options Plus HMO SNP, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

## Chapter 10. Ending your membership in the plan

### SECTION 5 Molina Medicare Options Plus HMO SNP must end your membership in the plan in certain situations

#### Section 5.1 When must we end your membership in the plan?

**Molina Medicare Options Plus HMO SNP must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
  - When Molina Medicare determines that you no longer meet the eligibility requirements you will receive a notification letter stating the reason for possible disenrollment. You will then have six months from the date of the letter to respond for reconsideration of your membership eligibility in Molina Medicare Options Plus HMO SNP.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

#### **Where can you get more information?**

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the back cover of this booklet).

## Chapter 10. Ending your membership in the plan

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### Section 5.2 We cannot ask you to leave our plan for any reason related to your health

#### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

### Section 5.3 You have the 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 make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

## **Chapter 11. Legal notices**

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<b>SECTION 1</b>	<b>Notice about governing law .....</b>	<b>154</b>
<b>SECTION 2</b>	<b>Notice about nondiscrimination .....</b>	<b>154</b>

## Chapter 11. Legal notices

### SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

### SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

## Chapter 12.

# Definitions of important words

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**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

## Chapter 12.

### Definitions of important words

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**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The general term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Deductible** – The amount you must pay for health care or prescriptions before our plan begins to pay.

**Disenroll or Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

**Dual Eligible Individual** – A person who qualifies for Medicare and Medicaid coverage.

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

**Grievance** - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

## Chapter 12. Definitions of important words

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**Home Health Aide** – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage after you have met your deductible and before your total drug expenses have reached \$2,930, including amounts you've paid and what our plan has paid on your behalf.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Institutional Special Needs Plan (SNP)** – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility (ies).

**Institutional Equivalent Special Needs Plan (SNP)** – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

**List of Covered Drugs (Formulary or "Drug List")** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy** – See "Extra Help."

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for Medicare Part A and Part B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and 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, a Medicare Cost Plan, or a Medicare Advantage Plan.

## Chapter 12. Definitions of important words

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**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Cost Plan** – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “network providers” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

**Organization Determination** – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

## Chapter 12. Definitions of important words

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**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**Part C** – see “**Medicare Advantage (MA) Plan.**”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Provider.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

## Chapter 12. Definitions of important words

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**Quality Improvement Organization (QIO)** – 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**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 also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

**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 injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Care** – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

<b>Molina Medicare Options Plus HMO SNP Member Services</b>	
<b>CALL</b>	1-800-665-0898 Calls to this number are free. Hours of operations are Monday through Sunday 8:00 AM to 8:00 PM, local time. Member Services also has free language interpreter services available for non-English speakers.
<b>TTY/TDD</b>	1-800-346-4128 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are Monday through Sunday 8:00 AM to 8:00 PM, local time.
<b>FAX</b>	1-801-858-0409
<b>WRITE</b>	Molina Medicare P.O. Box 8542 Midvale, UT 84047
<b>WEBSITE</b>	<a href="http://www.molinamedicare.com">www.molinamedicare.com</a>

<b>HICAP (California HICAP)</b>	
HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.	
<b>CALL</b>	1-800-434-0222
<b>TTY/TDD</b>	711
<b>WRITE</b>	HICAP Sacramento County: 1-800-434-0222 HICAP Services of Northern California 3950 Industrial Blvd., Suite 500 West Sacramento, CA 95691

