

# Summary Of Benefits

**UTAH**

Davis, Salt Lake, Utah, and Weber

## 2018

Healthy Advantage (HMO SNP)  
(877) 644-0344, TTY/TDD 711  
7 days a week, 8 a.m. – 8 p.m. local time

[MolinaHealthcare.com/Medicare](http://MolinaHealthcare.com/Medicare)



## About Healthy Advantage (HMO SNP)

Healthy Advantage (HMO SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website [www.MolinaHealthcare.com/Medicare](http://www.MolinaHealthcare.com/Medicare). Or, call us and we will send you a copy of the provider and pharmacy directories.

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

## Who can join?

To join **Healthy Advantage (HMO SNP)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Medicaid Utah Department of Health: Division of Medicaid & Health Financing, and live in our service area. Our service area includes the following counties in Utah: Davis, Salt Lake, Utah and Weber.

## What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website [www.MolinaHealthcare.com/Medicare](http://www.MolinaHealthcare.com/Medicare). Or, call us and we will send you a copy of the formulary.

## How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

## How to reach us:

You can call us 7 days a week, 8:00 a.m. to 8:00 p.m., local time

If you are a **Member** of this plan, call toll-free:  
(877) 644-0344; TTY/TDD 711

If you are **not a Member** of this plan, call toll-free:  
(866) 403-8293; TTY/TDD 711

Or visit our website: [www.MolinaHealthcare.com/Medicare](http://www.MolinaHealthcare.com/Medicare)

## Monthly Premium, Deductible and Limits

<b>Monthly Health Plan Premium</b>	<p>\$0-\$31.50 per month</p> <p>In addition, you must keep paying your Medicare Part B premium.</p> <p>If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.</p>
<b>Deductible</b>	<p>This plan has deductibles for some hospital and medical services.</p> <p>\$0 or \$183 per year for in-network services, depending on your level of Medicaid eligibility. This amount may change for 2018.</p> <p>\$0 to \$83 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.</p>
<b>Maximum Out-of-Pocket Responsibility (this does not include prescription drugs)</b>	<p>\$5,000 annually for services you receive from in-network providers.</p> <p>In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid by Utah Department of Health: Division of Medicaid &amp; Health Financing eligibility. Refer to the "<b>Medicare &amp; You</b>" handbook for Medicare-covered services. For Medicaid covered services by Utah Department of Health: Division of Medicaid &amp; Health Financing, refer to the Medicaid Coverage section in this document.</p> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p> <p>If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year.</p>

## Covered Medical and Hospital Benefits

### Healthy Advantage (HMO SNP)

#### INPATIENT HOSPITAL COVERAGE

*Prior authorization may be required*

The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.

In 2017 the amounts for each benefit period were \$0 or:

\$1,316 deductible for days 1 through 60  
\$329 copay per day for days 61 through 90  
\$658 copay per day for 60 lifetime reserve days

These amounts may change for 2018.

#### OUTPATIENT HOSPITAL COVERAGE

##### Outpatient hospital

0% or 20% of the cost

*Prior authorization may be required*

##### Ambulatory surgical center

0% or 20% of the cost

*Prior authorization may be required*

#### DOCTOR VISITS

##### Primary Care

0% or 20% of the cost

##### Specialists

0% or 20% of the cost

*Referral may be required*

## Covered Medical and Hospital Benefits

	Healthy Advantage (HMO SNP)
<b>PREVENTIVE CARE</b>	
	\$0 copay <ul style="list-style-type: none"> <li>• Abdominal aortic aneurysm screening</li> <li>• Alcohol misuse screenings &amp; counseling</li> <li>• Bone mass measurements (bone density)</li> <li>• Cardiovascular disease screening</li> <li>• Cardiovascular disease (behavioral therapy)</li> <li>• Cervical &amp; vaginal cancer screening</li> <li>• Colorectal cancer screening</li> <li>• Depression screenings</li> <li>• Diabetes screenings</li> <li>• Diabetes self-management training</li> <li>• Glaucoma tests</li> <li>• Hepatitis C screening test</li> <li>• HIV screening</li> <li>• Lung cancer screening</li> <li>• Mammograms (screening)</li> <li>• Nutrition therapy services</li> <li>• Obesity screenings &amp; counseling</li> <li>• One-time "Welcome to Medicare" preventive visit</li> <li>• Prostate cancer screenings</li> <li>• Sexually transmitted infections screening &amp; counseling</li> <li>• Vaccines including Flu shots, Hepatitis B shots, Pneumococcal shots</li> <li>• Tobacco use cessation counseling</li> <li>• Yearly "Wellness" visit</li> </ul>
<b>EMERGENCY CARE</b>	
Emergency Care	0% or 20% of the cost (up to \$80) waived if admitted within 24 hours
<b>URGENTLY NEEDED SERVICES</b>	
Urgently Needed Services	0% or 20% of the cost (up to \$65)

## Covered Medical and Hospital Benefits

	Healthy Advantage (HMO SNP)
<b>DIAGNOSTIC SERVICES/LABS/ IMAGING LAB SERVICES</b>	
<b>Diagnostic tests and procedures</b>  <i>Prior authorization may be required</i>	0% or 20% of the cost
<b>Lab services</b>	\$0 copay
<b>Diagnostic radiology (e.g., MRI, CT)</b>  <i>Prior authorization may be required</i>	0% or 20% of the cost
<b>Outpatient x-rays</b>	0% or 20% of the cost
<b>Therapeutic radiology</b>  <i>Prior authorization may be required</i>	0% or 20% of the cost
<b>HEARING SERVICES</b>	
<b>Medicare-covered diagnostic hearing and balance exam</b>  Exam to diagnose and treat hearing and balance issues	0% or 20% of the cost
<b>Routine hearing exam</b>  1 every year	\$0 copay
<b>Fitting for hearing aid/evaluation</b>  1 every 2 years	\$0 copay
<b>Hearing aids</b>	\$0 copay  Our plan pays up to \$1,000 every two years for hearing aids, both ears combined.

## Covered Medical and Hospital Benefits

Healthy Advantage (HMO SNP)	
<b>DENTAL SERVICES</b>	
<b>Medicare-covered dental services</b>	\$0 copay
<b>Preventive Dental</b>	<p>\$0 copay</p> <p>Oral Exams (up to 2 every year)  Cleanings (up to 2 every year)  Fluoride Treatment (up to 1 every year)  Dental X-Rays (up to 1 every year)</p> <p>Our plan pays up to \$1,250 every year for most dental services, including \$500 allowance for dentures.</p> <p>Only certain dental procedure codes apply. Refer to the Evidence of Coverage for further details.</p>
<b>Comprehensive Dental</b>	<p>\$0 copay</p> <p>Deep Cleaning (up to 4 quadrants every 2 years)  Fillings (up to 4 every year)  Simple Extractions (up to 5 every year)  Denture Adjustments (up to 2 every year)  Dentures: Covered. The plan pays up to \$500 for dentures every year  Crowns &amp; Crown Repairs: Covered  Bridges &amp; Bridge Repairs: Covered  Endodontics: Covered</p> <p>Our plan pays up to \$1,250 every year for most dental services, including \$500 allowance for dentures.</p> <p>Only certain dental procedure codes apply. Refer to the Evidence of Coverage for further details.</p>
<b>VISION SERVICES</b>	
<b>Medicare-covered vision exam to diagnose/treat diseases of the eye (including yearly glaucoma screening)</b>	0% or 20% of the cost
<b>Eyeglasses or contact lenses after cataract surgery</b>	\$0 copay

## Covered Medical and Hospital Benefits

	Healthy Advantage (HMO SNP)
<b>Routine eye exam</b>  1 every year	\$0 copay
<b>Eyewear</b> <ul style="list-style-type: none"> <li>• Contact lenses</li> <li>• Eyeglasses (frames and lenses)</li> <li>• Eyeglass frames</li> <li>• Eyeglass lenses</li> <li>• Upgrades</li> </ul>	\$0 copay  Our plan pays up to \$150 every year for eyewear.
<b>MENTAL HEALTH SERVICES</b>	
<b>Mental Health Services</b>  <i>Prior authorization may be required</i>	<p>Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital.</p> <p>The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.</p> <p>Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days.</p> <p>In 2017 the amounts for each benefit period were \$0 or:</p> <p>\$1,316 deductible for days 1 through 60            \$329 copay per day for days 61 through 90            \$658 copay per day for 60 lifetime reserve days</p> <p>These amounts may change for 2018.</p>
<b>Outpatient individual/group therapy visit</b>	0% or 20% of the cost



## Covered Medical and Hospital Benefits

Healthy Advantage (HMO SNP)	
<b>SKILLED NURSING FACILITY</b>	
No prior hospitalization is required	Our plan covers up to 100 days in a SNF
<i>Prior authorization may be required</i>	<p>In 2017 the amounts for each benefit period were \$0 or:</p> <p>\$0 for days 1 through 20</p> <p>\$164.50 per day for days 21 through 100 each benefit period</p> <p>These amounts may change for 2018.</p>
<b>PHYSICAL THERAPY</b>	
<b>Physical Therapy and Speech Therapy Services</b>	0% or 20% of the cost
<i>Prior authorization may be required</i>	
<b>Cardiac and Pulmonary Rehabilitation</b>	0% or 20% of the cost
<b>Occupational Therapy Services</b>	0% or 20% of the cost
<i>Prior authorization may be required</i>	
<b>AMBULANCE</b>	
<i>Prior authorization required for non-emergent ambulance only.</i>	0% or 20% of the cost
<b>TRANSPORTATION</b>	
24 one-way trips to and from plan approved locations.	\$0 copay

## Prescription Drug Benefits

### MEDICARE PART B DRUGS

**Chemotherapy drugs** 0% or 20% of the cost

*Prior authorization may be required*

**Other Part B drugs** 0% or 20% of the cost

*Prior authorization rules apply to select drugs.*

### INITIAL COVERAGE STAGE

Depending on your level of Medicaid eligibility, your Part D deductible may vary. After you pay your applicable deductible you begin in this stage when you fill your first prescription of the year.

During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.

If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$3,750.

Depending on your income and institutional status, you pay the following:

	Standard Retail Pharmacy and Mail Order Pharmacy
<b>Tier 1 (Preferred Generic)</b>	\$0 copay
One, two or three month supply	
<b>Tier 2 (Generic)</b>	\$0 copay
One, two or three month supply	
<b>Tier 3 (Preferred Brand)</b>	For generic drugs (including brand drugs treated as generic), either:
One, two or three month supply	\$0 copay; or \$1.25 copay; or \$3.35 copay
	For all other drugs, either:
	\$0 copay; or \$3.70 copay; or \$8.35 copay

## Prescription Drug Benefits

<b>Tier 4 (Non-Preferred Drug)</b>	For generic drugs (including brand drugs treated as generic), either:
One, two or three month supply	\$0 copay; or \$1.25 copay; or \$3.35 copay
	For all other drugs, either:
	\$0 copay; or \$3.70 copay; or \$8.35 copay
<b>Tier 5 (Specialty Tier)</b>	For generic drugs (including brand drugs treated as generic), either:
One month supply	\$0 copay; or \$1.25 copay; or \$3.35 copay
Specialty drugs are limited to a one-month supply.	For all other drugs, either:
	\$0 copay; or \$3.70 copay; or \$8.35 copay

### COVERAGE GAP STAGE

During this stage, you pay 35% of the price for brand name drugs (plus a portion of the dispensing fee) and 44% of the price for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$5,000. This amount and rules for counting costs toward this amount have been set by Medicare.

### CATASTROPHIC COVERAGE STAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$5,000 the plan will pay most of the costs of your drugs.

## Additional Covered Benefits

Healthy Advantage (HMO SNP)	
<b>DIALYSIS SERVICES</b>	
	0% or 20% of the cost
<b>CHIROPRACTIC CARE</b>	
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position)	0% or 20% of the cost
<b>HOME HEALTH CARE</b>	
<i>Prior authorization may be required</i>	\$0 copay
<b>OUTPATIENT SUBSTANCE ABUSE</b>	
Group therapy visit	0% or 20% of the cost
Individual therapy visit	0% or 20% of the cost
<b>OVER-THE-COUNTER ITEMS</b>	
<b>Over-the-Counter Items</b>	\$0 copay
Allowance rolls over every 3 months but expires at the end of the calendar year.	\$75 allowance every 3 months
<b>OUTPATIENT BLOOD SERVICES</b>	
<b>Outpatient Blood Services</b>	0% or 20% of the cost
3-Pint deductible waived.	
<b>MEALS BENEFIT</b>	
Standard meal cycle is a 2 week menu with a total of 28 meals delivered to the Member, based on Member need. Additional 28 meals with approval.	\$0 copay
<i>Prior authorization may be required</i>	

## Additional Covered Benefits

### Healthy Advantage (HMO SNP)

#### FOOT CARE (PODIATRY SERVICES)

**Medicare-covered foot exam and treatment** 0% or 20% of the cost

Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.

**Routine foot care** \$0 copay

Up to 12 visit(s) of routine foot care every year

#### MEDICAL EQUIPMENT / SUPPLIES

**Durable Medical Equipment (e.g., wheelchairs, oxygen)** 0% or 20% of the cost

*Prior authorization may be required*

**Prosthetics/Medical Supplies** 0% or 20% of the cost

*Prior authorization may be required*

**Diabetic Supplies and Services** \$0 copay

*Prior authorization not required for preferred manufacturer*

#### HEALTH AND WELLNESS EDUCATION PROGRAMS

**Health Education** \$0 copay

The Health Plan has health programs to help you learn to manage your health conditions including health education, learning materials, health advice and care tips.

**Additional Covered Benefits**

	<b>Healthy Advantage (HMO SNP)</b>
<b>24-Hour Nurse Advice Line</b>  Available 24 hours a day, 7 days a week.	\$0 copay
<b>Nutritional/Dietary Benefit</b>  12 Individual or group sessions every year. 30-60 minutes of individual telephonic nutritional counseling upon referral.	\$0 copay
<b>Fitness Benefit</b>  FitnessCoach offers Members access to contracted fitness facilities and/or Home Fitness Kits for Members who prefer to exercise at home or while traveling.	\$0 copay
<b>Remote Access Technologies</b>	\$0 copay

## Summary of Medicaid-Covered Benefits

Your state Medicaid program can be reached through the office of the Utah Department of Health: Division of Medicaid & Health Financing.

A person who is entitled to both Medicare and medical assistance from a State Medicaid plan is considered a dual eligible. As a dual eligible beneficiary your services are paid first by Medicare and then by Medicaid. Your Medicaid coverage varies depending on your income, resources, and other factors. Benefits may include full Medicaid benefits and/or payment of some or all of your Medicare cost-share (premiums, deductibles, coinsurance, or copays). Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Medicare-covered services.

**Below is a list of dual eligibility coverage categories for beneficiaries who may enroll in the Healthy Advantage (HMO SNP) Plan:**

- **Qualified Medicare Beneficiary (QMB):** Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts only. You receive Medicaid coverage of Medicare cost-share but are not otherwise eligible for full Medicaid benefits.
- **QMB+:** Medicaid pays your Medicare Part A and Part B premiums, deductibles, coinsurance, and copayment amounts. You receive Medicaid coverage of Medicare cost-share and are eligible for full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Medicaid pays your Medicare Part B premium only. You are not eligible for other Medicaid benefits.
- **SLMB+:** Medicaid pays your Medicare Part B premium and provides full Medicaid benefits.
- **Qualifying Individual (QI):** Medicaid pays your Medicare Part B premium only. You are not otherwise eligible for Medicaid benefits.
- **Full-Benefit Dual Eligible (FBDE):** At times, individuals may qualify for both limited coverage of Medicare cost-sharing as well as full Medicaid benefits.
- **Qualified Disabled and Working Individual (QDWI):** Eligible for Medicaid payment of your Medicare Part A premium only. You are not otherwise eligible for Medicaid.

**If you are a QMB or QMB+ Beneficiary:**

You have a \$0 cost-share, except for Part D prescription drug copays, as long as you remain a QMB or QMB+ Member.

**If you are a SLMB+ or FBDE Beneficiary:**

You are eligible for full Medicaid benefits and, at times, limited Medicare cost-share. As such your cost-share is 0% or 20%\*. Typically your cost-share is 0% when the service is covered by both Medicare and Medicaid. Additionally, preventive wellness exams and supplemental benefits provided by Healthy Advantage are also at a \$0 cost-share. In rare instances, you will pay 20%\* when a service or benefit is not covered by Medicaid (see the chart below).

**If you are a SLMB, QI, or QDWI Beneficiary:**

Because Medicaid does not pay your cost-share, and you do not have full Medicaid benefits, your cost-share is typically 20%\*. There are a few exceptions such as preventive wellness exams and supplemental benefits provided by Healthy Advantage, where you will have a \$0 cost-share.

Note – Preventive wellness exams and supplemental benefits have a \$0 cost-share.

**Eligibility Changes:**

It is important to read and respond to all mail that comes from Social Security and your state Medicaid office and to maintain your Medicaid eligibility status.

Periodically, as required by CMS, we will check the status of your Medicaid eligibility as well as your dual eligible category. If your eligibility status changes, your cost-share may also change from 0% to 20%\* or from 20%\* to 0%. If you lose Medicaid coverage entirely, you will be given a grace period so that you can reapply for Medicaid and become reinstated if you still qualify.

If you no longer qualify for Medicaid you may be involuntarily disenrolled from the Plan. Your state Medicaid agency will send you notification of your loss of Medicaid or change in Medicaid category. We may also contact you to remind you to reapply for Medicaid. For this reason it is important to let us know whenever your mailing address and/or phone number changes.

If you are currently entitled to receive full or partial Medicaid benefits please see your Medicaid member handbook or other state Medicaid documents for full details on your Medicaid benefits, limitations, restrictions, and exclusions. The Utah Medicaid program can be reached through the office of the Utah Department of Health: Division of Medicaid & Health Financing.

\*Annual deductible for Part B services, and 20% coinsurance (as applicable), in addition to varying cost-share amounts for Part A services apply when Member's cost-share amount is not 0%.

**How to Read the Medicaid Benefit Chart**

The chart below shows what services are covered by Medicare and Medicaid. You will see the word "Covered" under the Medicaid column if Medicaid also covers a service that is covered under the **Healthy Advantage (HMO SNP)** Plan. The chart applies only if you are entitled to benefits under your state's Medicaid program. Your cost-share varies based on your Medicaid category.

**Medicaid-Covered Benefits Chart**

	<b>HEALTHY ADVANTAGE (HMO SNP)</b>	<b>MEDICAID STATE PLAN</b>
<b>IMPORTANT INFORMATION</b>		
<b>Premium and Other Important Information</b>  If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.	<b>General</b> \$0 - \$31.50 monthly plan premium  <b>In-Network</b> \$0 or \$183 deductible per year for in-network services. This amount may change for 2018.  \$0 to \$83 per year for Part D prescription drugs except for drugs listed on Tier 1 and Tier 2 which are excluded from the deductible.  \$5,000 out-of-pocket limit for Medicare-covered services.  Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for Original Medicare services	Medicaid assistance with premium payments and cost-share may vary based on your level of Medicaid eligibility.



## Medicaid-Covered Benefits Chart

	HEALTHY ADVANTAGE (HMO SNP)	MEDICAID STATE PLAN
<b>Doctor and Hospital Choice</b> <i>(For more information, see Emergency Care and Urgently Needed Care.)</i>	<b>In-Network</b> You must go to network doctors, specialists, and hospitals.  Referral required for network specialists (for certain benefits).	You must go to doctors, specialists, and hospitals that accept Medicaid assignment.
<b>OUTPATIENT CARE SERVICES</b>		
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Ambulance Services</b> <i>(Medically necessary ambulance services)</i>	Covered	Covered
<b>Cardiac and Pulmonary Rehabilitation Services</b>	Covered	Covered (Requires prior authorization)
<b>Chiropractic Services</b>	Covered	Covered for pregnant women and enrollees eligible for CHEC – (12 visits in a 12 month period covered.) PA required for additional services.  Not Covered for all others
<b>Dental Services</b>	Covered	Covered for eligible Medicaid members who are pregnant, disabled, blind or qualify for Child Health Evaluation and Care (CHEC).  Not Covered for all others
<b>Diabetes Programs and Supplies</b>	Covered	Covered
<b>Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</b>	Covered	Covered
<b>Doctor Office Visits</b>	Covered	Covered
<b>Durable Medical Equipment</b> <i>(Includes wheelchairs, oxygen, etc.)</i>	Covered	Covered - requires a doctor's face to face initial order and prior approval from State Medicaid.

## Medicaid-Covered Benefits Chart

	<b>HEALTHY ADVANTAGE (HMO SNP)</b>	<b>MEDICAID STATE PLAN</b>
<b>Emergency Care</b> <i>(You may go to any emergency room if you reasonably believe you need emergency care.)</i>	Covered	Covered
<b>Hearing Services</b>	Covered	Covered for pregnant women and enrollees eligible for CHEC Not Covered for all others
<b>Home Health Service</b> <i>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>	Covered	Covered - requires a doctor's face to face initial order and prior approval from State Medicaid.
<b>Outpatient Mental Health Care</b>	Covered	Covered (through approved Medicaid providers)
<b>Outpatient Rehabilitation Services</b> <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i>	Covered	Covered Occupational Therapy Physical Therapy Speech Therapy covered only for pregnant women and CHEC enrollees. (There may be a limit to the number of visits covered.)
<b>Outpatient Services</b>	Covered	Covered
<b>Outpatient Substance Abuse Care</b>	Covered	Covered – through Medicaid approved providers.
<b>Over-the-Counter Items</b>	Covered	Covered Limited Coverage with prescription from MD
<b>Podiatry Services</b>	Covered	Covered

## Medicaid-Covered Benefits Chart

	HEALTHY ADVANTAGE (HMO SNP)	MEDICAID STATE PLAN
<b>Prosthetic Devices</b> <i>(Includes braces, artificial limbs and eyes, etc.)</i>	Covered	Covered
<b>Transportation Services</b> <i>(Routine)</i>	Covered	Covered for Enrollees on the Traditional Medicaid program (with restrictions)
<b>Urgently Needed Services</b> <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i>	Covered	Covered (Some limitations apply)
<b>Vision Services</b>	Covered	Covered – 1 Eye exam each year. Covered – Approved eyewear only for pregnant women and enrollees eligible for CHEC once every 24 months. (Restrictions apply if required more often.) Eyewear is not Covered for all others
<b>Wellness/Education and other Supplemental Benefit Programs</b>	Covered	Covered
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care</b> <i>(Includes Substance Abuse and Rehabilitation Services)</i>	Covered	Covered– (Must have a referral from your doctor unless it is an emergency.) Restrictions apply with Inpatient Substance Abuse
<b>Inpatient Mental Health Care</b>	Covered	Covered (through approved Medicaid providers)
<b>Skilled Nursing Facility (SNF)</b> <i>(In a Medicare-certified skilled nursing facility)</i>	Covered	Covered for the first 30 days by the Health Plan. Longer than 30 days in a SNF will be covered directly through State Medicaid. (Some limitations apply)

## Medicaid-Covered Benefits Chart

	HEALTHY ADVANTAGE (HMO SNP)	MEDICAID STATE PLAN
<b>PREVENTIVE SERVICES</b>		
<b>Kidney Disease and Conditions</b>	Covered	Covered (Some limitations apply)
<b>Preventive Services</b>	Covered	Covered
<b>HOSPICE</b>		
<b>Hospice</b>	Not Covered	Covered
<b>PRESCRIPTION DRUG BENEFITS</b>		
<b>Outpatient Prescription Drugs</b>	Covered	Covered Generic brands covered, some prescriptions require approval.

For Members who are entitled to full benefits under Medicaid, listed below are additional benefits that you may be entitled to. These are additional Medicaid benefits that are covered by your state Medicaid program but may not be covered under the **Healthy Advantage (HMO SNP)** Plan:

## Additional Medicaid Benefits

BENEFITS	MEDICAID COVERAGE
<b>Birth Control</b>	Covered
<b>Maternity Care</b>	Covered
<b>Mental Health- Peer Support Services</b>	Covered- (through approved Medicaid providers.)
<b>Mental Health-Psychosocial Rehabilitative Services</b>	Covered- (through approved Medicaid providers.)
<b>Midwife Services</b>	Covered
<b>Prescriptions</b>	Covered – Generic brands. Some prescriptions require approval. If you have Medicare, Medicaid does not pay, Medicare Part D covers prescriptions.

**Additional Medicaid Benefits**

BENEFITS	MEDICAID COVERAGE
<b>Tobacco Cessation Services</b>	Covered for pregnant women. (Limited to 4 intermediate sessions and 3 intensive sessions in a 12 month period.) Some services and products are Covered for other members.
<b>Waiver Programs</b>	Covered under specific criteria

## Find out more

### You have choices about how to get your Medicare benefits

One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. Another choice is to get your Medicare benefits by joining a Medicare health plan (such as Healthy Advantage (HMO SNP)). If you want to know more about the coverage and costs of Original Medicare, look in your current "**Medicare & You**" handbook. View it online at <http://www.medicare.gov> or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Healthy Advantage (HMO SNP)** covers and what you pay. If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on <http://www.medicare.gov>.

This information is available in other formats, such as Braille, large print, and audio.

Healthy Advantage (HMO SNP) is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in Healthy Advantage (HMO SNP) depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Premiums and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium. As a dual Member, your State may cover your Part B premium, based upon your level of Medicaid eligibility.

The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Premium, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help you receive. Please contact the plan for further details.



**Your Extended Family.**

Member Services (877) 644-0344, TTY/TDD 711  
7 days a week, 8 a.m. – 8 p.m. local time