2019 Benefits-At-A-Glance

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MOLINA HEALTHCARE

Molina Medicare Options Plus HMO SNP
Michigan
Genesee, Kent, Lapeer, Macomb, Montcalm, Oakland, Saginaw and Wayne Counties

2019 Benefits-At-A-Glance Molina Medicare Options Plus

Monthly Premium, Deductible and Limits	
Monthly Health Plan Premium	$0–$30.10 per month In addition, you must keep paying your Medicare Part B premium. If you get Extra Help from Medicare, your monthly plan premium will be lower or you might pay nothing.
Deductible	This plan has deductibles for some hospitals and medical services. $0 or $183 per year for in-network services, depending on your level of Medicaid eligibility. This amount may change for 2019. $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.
Maximum Out-of-Pocket Responsibility *(This does not include prescription drugs)*	$6,700 annually for services you receive from in-network providers. In this plan, you pay nothing for Medicare-covered services, depending on your level of Medicaid by Michigan Department of Health and Human Services (MDHHS) eligibility. Refer to the "Medicare & You" handbook for Medicare-covered services. For Medicaid covered services by Michigan Department of Health and Human Services (MDHHS), refer to the Medicaid coverage section in the Summary of Benefits. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs. 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.

Covered Medical and Hospital Benefits	
Inpatient Hospital Coverage *(prior authorization may be required)*	In 2018 the amounts for each benefit period were $0 or: $1,340 deductible for days 1–60 $335 copay per day for days 61–90 $670 copay per day for 60 lifetime reserve days *These amounts may change for 2019*
Outpatient Hospital Coverage *(prior authorization may be required)*	
• Outpatient Hospital	0% or 20% of the cost
• Ambulatory Surgical Center	0% or 20% of the cost
Doctor Visits	
• Primary Care	0% or 20% of the cost
• Specialists *(referral may be required)*	0% or 20% of the cost

Covered Medical and Hospital Benefits (Continued)	
Preventive Care • Abdominal aortic aneurysm screening • Alcohol misuse screenings and counseling • Bone mass measurement (bone density) • Cardiovascular disease screening • Cardiovascular disease (behavioral therapy) • Cervical and vaginal cancer screening • Colorectal cancer screening • Depression screenings • Diabetes screenings • Diabetes self-management training • Glaucoma tests • Hepatitis C screening test • HIV screening • Lung cancer screening • Mammograms (screening) • Nutrition therapy services • Obesity screenings and counseling • One-time "Welcome to Medicare" preventive visit • Prostate cancer screenings • Sexually transmitted infections screening and counseling • Vaccines including Flu shots, Hepatitis B shots, Pneumococcal shots • Tobacco use cessation counseling • Yearly "Wellness" visit	$0 copay
Emergency Care	0% or 20% of the cost (up to $80) waived if admitted within 24 hours
Urgently Needed Services	0% or 20% of the cost (up to $65)
Diagnostic Services/Lab/Imaging Lab Services	
• Diagnostic Tests and Procedures *(prior authorization may be required)*	0% or 20% of the cost
• Lab Services	0% or 20% of the cost
• Diagnostic Radiology Services (e.g., MRI, CT) *(prior authorization may be required)*	0% or 20% of the cost
• Outpatient X-Rays	0% or 20% of the cost
• Therapeutic Radiology *(prior authorization may be required)*	0% or 20% of the cost
Hearing Services	
• Medicare-covered diagnostic hearing and balance exam (to diagnose and treat hearing and balance issues)	0% or 20% of the cost

Covered Medical and Hospital Benefits (Continued)	
Dental Services	
• Medicare-covered dental services	$0 copay
• Preventive Dental	$0 office visit copay
▪ No maximum allowance per year	
▪ Oral Exams: 2 per year, comprehensive periodontal exams covered once per provider per lifetime	
▪ Prophylaxis (cleaning): up to 2 every year	
▪ Fluoride Treatment: up to 2 every year	
▪ X-Rays: Periapicals (up to 6 per year), Bitewings (up to 4 per year), Panoramic Radiographic (once every 5 years)	
• Comprehensive Dental	
▪ $1,500 annual maximum allowance	
▪ Non-Routine: Scaling (up to 4 quadrants every 24 months), Full Mouth Debridement (1 every year), Periodontal Maintenance (up to 2 per 12 months), and Palliative Emergency Treatment (up to 4 per year)	
▪ Extractions: Simple extractions (up to 8 per year), Surgical removal of erupted and impacted teeth (up to 3 per year)	
▪ Restorative Services: up to 6 restorations per year, no more than 12 surfaces per year	
▪ Crowns: up to 2 per year, no more than 1 per tooth every 5 years	
▪ Denture Adjustments (up to 4 per year), Dentures (covered once every 5 years), Endodontics (1 per tooth per year)	
▪ Other Services: Deep Sedation with Oral Surgery and Intravenous with Oral Surgery (Unlimited based on Medical Necessity); Intraoral and Extraoral incision and drainage (1 per tooth per lifetime)	
Vision Services	
• Medicare-covered vision exam to diagnose/treat disease of the eye (including yearly glaucoma screening)	0% or 20% of the cost
▪ Eyeglasses or contact lenses after cataract surgery	
• Routine Eye Exam: 1 every year	$0 copay
• Eyewear: our plan pays for up to $200 allowance every 2 years for eyewear	0% or 20% of the cost
▪ Contact lenses, Eyeglasses (frames and lenses), Eyeglass frames, Eyeglass lenses and Upgrades	
Mental Health Services *(prior authorization may be required)*	
• Inpatient Visit	In 2018 the amounts for each benefit period were $0 or: $1,340 deductible for days 1–60 $335 copay per day for days 61–90 $670 copay per day for 60 lifetime reserve days *These amounts may change for 2019*
• Outpatient Individual/Group Therapy Visit	0% or 20% of the cost

Covered Medical and Hospital Benefits (Continued)	
Skilled Nursing Facility (SNF) *(prior authorization may be required)* Our plan covers up to 100 days in a SNF; no prior hospitalization is required	In 2018 the amounts for each benefit period were $0 or: $0 for days 1–20 $167.50 per day for days 21–100 each benefit period *These amounts may change for 2019*
Physical Therapy • Physical Therapy and Speech Therapy Services *(prior authorization may be required)* • Cardiac and Pulmonary Rehabilitation • Occupational Therapy Services *(prior authorization may be required)*	 0% or 20% of the cost 0% or 20% of the cost 0% or 20% of the cost
Ambulance *(prior authorization required for non-emergent ambulance only)*	0% or 20% of the cost
Transportation 22 one-way trips to and from plan approved locations	$0 copay
Prescription Drug Benefits	
Medicare Part B Drugs *(prior authorization may be required)* • Chemotherapy Drugs • Other Part B Drugs	 0% or 20% of the cost 0% or 20% of the cost

Tier/Supply	Standard Retail Pharmacy and Mail Order Pharmacy
Tier 1: Preferred Generic	
• One, two or three month supply	$0 copay
Tier 2: Generic	
• One, two or three month supply	$0 copay
Tier 3: Preferred Brand	
• One, two or three month supply	For generic drugs (including brand drugs treated as generic) either: $0 or $1.25 or $3.40 copay For all other drugs either: $0 or $3.80 or $8.50 copay
Tier 4: Non-Preferred Drug	
• One, two or three month supply	For generic drugs (including brand drugs treated as generic) either: $0 or $1.25 or $3.40 copay For all other drugs either: $0 or $3.80 or $8.50 copay
Tier 5: Specialty Tier	
• One month supply *(specialty drugs are limited to a one-month supply)*	For generic drugs (including brand drugs treated as generic) either: $0 or $1.25 or $3.40 copay For all other drugs either: $0 or $3.80 or $8.50 copay

Additional Covered Benefits	
Dialysis Services	0% or 20% of the cost
Chiropractic Care • Medicare-Covered Chiropractic Services ▪ 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
Home Health Care *(prior authorization may be required)*	$0 copay
Outpatient Substance Abuse • Group Therapy Visit • Individual Therapy Visit	 0% or 20% of the cost 0% or 20% of the cost
Over-the-Counter Items	$0 copay $240 allowance every 3 months; allowance expires at the end of the calendar year
Outpatient Blood Services	0% or 20% of the cost
Meals Benefit *(prior authorization may be required)* 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
Foot Care (Podiatry Services) • Medicare-covered foot exam and treatment ▪ Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions • Routine Foot Care: up to 6 visits of routine foot care every year	 0% or 20% of the cost $0 copay
Medical Equipment/Supplies • Durable Medical Equipment (e.g., wheelchairs, oxygen) *(prior authorization may be required)* • Prosthetics/Medical Supplies *(prior authorization may be required)* • Diabetic Supplies *(prior authorization not required for preferred manufacturer)*	 0% or 20% of the cost 0% or 20% of the cost $0 copay
Health and Wellness Education Programs	
Health Education 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	$0 copay
24-Hour Nurse Advice Line Available 24 hours a day, 7 days a week	$0 copay
Nutritional/Dietary Benefit 12 individual or group sessions every year; individual telephonic nutrition counseling upon request	$0 copay
Fitness Benefit 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

Your Enrollment Options

Enroll Now – If you're at a benefits presentation today, enroll with your agent.

By Phone – Call **(866) 713-5070, TTY 711,** 7 days a week, 8 a.m. to 8 p.m., local time. We are here to answer your questions and can help you enroll over the phone.

Schedule an in-home appointment with one of our agents.

Online – Visit MolinaHealthcare.com/Medicare

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ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-665-3086 (رقم هاتف الصم والبكم: 711).
This information is not a complete description of benefits. Call (800) 665-3086, TTY 711, for more information. Authorization and/or referral may be required. You must continue to pay your Medicare Part B premium. As a full dual member, your State may cover your Part B premium, based upon your level of Medicaid eligibility. Benefits, premiums and/or copayments/coinsurance may change on January 1, 2019. H5926_19_4041_63_MISNPBAAG_M Accepted 9/22/18

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