



**2015 SUMMARY OF BENEFITS  
MICHIGAN: H5926  
PLAN 001**

**MOLINA MEDICARE OPTIONS PLUS  
(HMO SNP)**

January 1, 2015 – December 31, 2015

Genesee, Kent, Lapeer, Macomb, Montcalm, Oakland, Saginaw,  
and Wayne



## SUMMARY OF BENEFITS

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January 1, 2015 – December 31, 2015

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."

### **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 Molina Medicare Options Plus (HMO SNP)).

### **Tips for comparing your Medicare choices**

This Summary of Benefits booklet gives you a summary of what Molina Medicare Options Plus (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>.

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.

### **Sections in this booklet**

- Things to Know About Molina Medicare Options Plus (HMO SNP)
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at (800) 665-3072.

Este documento puede estar disponible para personas que no hablan el idioma inglés. Para más información, llámenos al (800) 665-3072.

### **Things to Know About Molina Medicare Options Plus (HMO SNP)**

#### Hours of Operation

You can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern Time.

#### Molina Medicare Options Plus (HMO SNP) Phone Numbers and Website

- If you are a **member** of this plan, call toll-free (800) 665-3072.
- If you are **not a member** of this plan, call toll-free (866) 403-8293.
- Our website: <http://www.molinahealthcare.com/medicare>

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### Who can join?

To join Molina Medicare Options Plus (HMO SNP), you must be entitled to Medicare Part A, be enrolled in Medicare Part B and Medicaid by Michigan Department of Community Health and live in our service area.

Our service area includes the following counties in Michigan: Genesee, Kent, Lapeer, Macomb, Montcalm, Oakland, Saginaw, and Wayne.

### Which doctors, hospitals, and pharmacies can I use?

Molina Medicare Options Plus (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:

<http://www.molinahealthcare.com/medicare>.

Or, call us and we will send you a copy of the provider and pharmacy directories.

### What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what* is covered by Original Medicare.** 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, <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 four "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.

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### MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

<p><b>How much is the monthly premium?</b></p>	<p>\$28.60 per month. In addition, you must keep paying your Medicare Part B premium.</p>
<p><b>How much is the deductible?</b></p>	<p>This plan has deductibles for some hospital and medical services.</p> <p>\$0 or \$147 per year for in-network services, depending on your level of Medicaid eligibility. This amount may change for 2015.</p> <p>This plan does not have a deductible for Part D prescription drugs.</p>
<p><b>Is there any limit on how much I will pay for my covered services?</b></p>	<p>Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care.</p> <p>In this plan, you may pay nothing for Medicare-covered services, depending on your level of Medicaid by Michigan Department of Community Health eligibility.</p> <p>Refer to the "<b>Medicare &amp; You</b>" handbook for Medicare-covered services. For Medicaid by Michigan Department of Community Health-covered services, refer to the Medicaid Coverage section in this document.</p> <p>Your yearly limit(s) in this plan:</p> <ul style="list-style-type: none"> <li>• \$6,700 for services you receive from in-network providers.</li> </ul> <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> <p>Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.</p>
<p><b>Is there a limit on how much the plan will pay?</b></p>	<p>Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.</p>

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### COVERED MEDICAL AND HOSPITAL BENEFITS

Note:

- Services with a <sup>1</sup> may require Prior Authorization.
- Services with a <sup>2</sup> may require a Referral from your doctor.

#### OUTPATIENT CARE AND SERVICES

<b>Acupuncture and Other Alternative Therapies</b>	Not covered
<b>Ambulance<sup>1</sup></b>	0% or 20% of the cost
<b>Chiropractic Care<sup>1</sup></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>Dental Services<sup>1</sup></b>	<p>Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing</p> <p>Dental services: \$10 copay for a single office visit that includes:</p> <ul style="list-style-type: none"> <li>• Cleaning (for up to 2 every year)</li> <li>• Dental x-ray(s) (for up to 1 every year)</li> <li>• Fluoride treatment (for up to 1 every year)</li> <li>• Oral exam (for up to 2 every year)</li> </ul> <p>Our plan pays up to \$1,000 every year for most dental services.</p> <p><i>Scaling up to 2 per quad./24 mo</i>  <i>Up to 4 restorations/yr</i>  <i>Simple extractions limited to 5/yr</i>  <i>Up to 2 of any 4 denture adjust./yr</i>  <i>\$500 Dentures max allowance every 3 yrs, but \$250 max allowance per denture plate every 3 yrs. \$500 Dentures max counts toward \$1000 Max Plan Benefit Coverage Amount.</i></p>
<b>Diabetes Supplies and Services<sup>1</sup></b>	<p>Diabetes monitoring supplies: You pay nothing</p> <p>Diabetes self-management training: You pay nothing</p> <p>Therapeutic shoes or inserts: You pay nothing</p> <p><i>Plan provides disease management program nutritional training for diabetics.</i></p>

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<p><b>Diagnostic Tests, Lab and Radiology Services, and X-Rays</b><sup>1,2</sup></p>	<p>Diagnostic radiology services (such as MRIs, CT scans): 0% or 20% of the cost</p> <p>Diagnostic tests and procedures: 0% or 20% of the cost</p> <p>Lab services: You pay nothing</p> <p>Outpatient x-rays: 0% or 20% of the cost</p> <p>Therapeutic radiology services (such as radiation treatment for cancer): 0% or 20% of the cost</p>
<p><b>Doctor's Office Visits</b><sup>1,2</sup></p>	<p>Primary care physician visit: 0% or 20% of the cost</p> <p>Specialist visit: 0% or 20% of the cost</p>
<p><b>Durable Medical Equipment</b> (Wheelchairs, oxygen, etc.)<sup>1</sup></p>	<p>0% or 20% of the cost</p> <p>If you go to a preferred vendor, your cost may be less. Contact us for a list of preferred vendors.</p>
<p><b>Emergency Care</b></p>	<p>0% or 20% of the cost</p> <p><i>Up to \$65 for Medicare-covered emergency room visits.</i></p>
<p><b>Foot Care</b> (Podiatry services)<sup>1</sup></p>	<p>Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: 0% or 20% of the cost</p> <p>Routine foot care (for up to 6 visits every year): You pay nothing</p>
<p><b>Hearing Services</b></p>	<p>Exam to diagnose and treat hearing and balance issues: 0% or 20% of the cost</p>
<p><b>Home Health Care</b><sup>1,2</sup></p>	<p>You pay nothing</p>

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<p><b>Mental Health Care<sup>1</sup></b></p>	<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 covers 90 days for an inpatient hospital stay.</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 2014 the amounts for each benefit period were \$0 or:</p> <ul style="list-style-type: none"> <li>• \$1,216 deductible for days 1 through 60</li> <li>• \$304 copay per day for days 61 through 90</li> <li>• \$608 copay per day for 60 lifetime reserve days</li> </ul> <p>These amounts may change for 2015.</p> <p>Outpatient group therapy visit: 0% or 20% of the cost</p> <p>Outpatient individual therapy visit: 0% or 20% of the cost</p>
<p><b>Outpatient Rehabilitation<sup>1,2</sup></b></p>	<p>Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): 0% or 20% of the cost</p> <p>Occupational therapy visit: 0% or 20% of the cost</p> <p>Physical therapy and speech and language therapy visit: 0% or 20% of the cost</p>
<p><b>Outpatient Substance Abuse<sup>1</sup></b></p>	<p>Group therapy visit: 0% or 20% of the cost</p> <p>Individual therapy visit: 0% or 20% of the cost</p>
<p><b>Outpatient Surgery<sup>1,2</sup></b></p>	<p>Ambulatory surgical center: 0% or 20% of the cost</p> <p>Outpatient hospital: 0% or 20% of the cost</p>



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<b>Over-the-Counter Items</b>	<p>Please visit our website to see our list of covered over-the-counter items.</p> <p><i>\$15 monthly allowance for plan-approved non-prescription OTC products.</i></p>
<b>Prosthetic Devices</b> <i>(Braces, artificial limbs, etc.)<sup>1</sup></i>	<p>Prosthetic devices: 0% or 20% of the cost</p> <p>Related medical supplies: 0% or 20% of the cost</p>
<b>Renal Dialysis</b>	<p>0% or 20% of the cost</p>
<b>Transportation</b>	<p>You pay nothing</p> <p><i>21 one-way trips to and from plan-approved locations.</i></p> <p><i>Transportation could include a van, sedan, wheelchair equipped vehicle, ambulance and stretcher van.</i></p>
<b>Urgent Care</b>	<p>0% or 20% of the cost</p>
<b>Vision Services</b>	<p>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 0% or 20% of the cost</p> <p>Routine eye exam (for up to 1 every year): You pay nothing</p> <p>Contact lenses: You pay nothing</p> <p>Eyeglasses (frames and lenses): You pay nothing</p> <p>Eyeglass frames: You pay nothing</p> <p>Eyeglass lenses: You pay nothing</p> <p>Eyeglasses or contact lenses after cataract surgery: You pay nothing</p> <p>Our plan pays up to \$200 every two years for eyewear.</p> <p><i>Separate Office Visit Cost Share: If provider bills an office visit in conjunction with this service, PCP or specialist office visit cost share may apply.</i></p> <p><i>Cost share will not be applied on any preventive services that are included in this service category.</i></p>

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### PREVENTIVE CARE

#### Preventive Care

You pay nothing

Our plan covers many preventive services, including:

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colonoscopy
- Colorectal cancer screenings
- Depression screening
- Diabetes screenings
- Fecal occult blood test
- Flexible sigmoidoscopy
- HIV screening
- Medical nutrition therapy services
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
- Sexually transmitted infections screening and counseling
- Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots
- "Welcome to Medicare" preventive visit (one-time)
- Yearly "Wellness" visit

Any additional preventive services approved by Medicare during the contract year will be covered.

Annual physical exam: You pay nothing

### HOSPICE

#### Hospice

You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care.

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### INPATIENT CARE

#### Inpatient Hospital Care<sup>1</sup>

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 covers 90 days for an inpatient hospital stay.

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 2014 the amounts for each benefit period were \$0 or:

- \$1,216 deductible for days 1 through 60
- \$304 copay per day for days 61 through 90
- \$608 copay per day for 60 lifetime reserve days

These amounts may change for 2015.

#### Inpatient Mental Health Care

For inpatient mental health care, see the "Mental Health Care" section of this booklet.

#### Skilled Nursing Facility (SNF)<sup>1</sup>

Our plan covers up to 100 days in a SNF.

In 2014 the amounts for each benefit period were \$0 or:

- You pay nothing for days 1 through 20
- \$152 copay per day for days 21 through 100

These amounts may change for 2015.

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### PRESCRIPTION DRUG BENEFITS

<b>How much do I pay?</b>	For Part B drugs such as chemotherapy drugs <sup>1</sup> : 0% or 20% of the cost  Other Part B drugs <sup>1</sup> : 0% or 20% of the cost
<b>Initial Coverage</b>	Our plan does not have a deductible for Part D prescription drugs.  You pay the following: You may get your drugs at network retail pharmacies and mail order pharmacies.

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<b>STANDARD RETAIL COST-SHARING</b>			
<b>Tier</b>	<b>One-month Supply</b>	<b>Two-month Supply</b>	<b>Three-month Supply</b>
<b>Tier 1 (Generic)</b>	\$0	\$0	\$0
<b>Tier 2 (Preferred Brand)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>
<b>Tier 3 (Non-Preferred Brand)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>
<b>Tier 4 (Specialty Tier)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	<b>Not Offered</b>	<b>Not Offered</b>

## SUMMARY OF BENEFITS

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<b>STANDARD MAIL ORDER COST-SHARING</b>			
<b>Tier</b>	<b>One-month Supply</b>	<b>Two-month Supply</b>	<b>Three-month Supply</b>
<b>Tier 1 (Generic)</b>	\$0	\$0	\$0
<b>Tier 2 (Preferred Brand)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>
<b>Tier 3 (Non-Preferred Brand)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>
<b>Tier 4 (Specialty Tier)</b>	For generic drugs (including brand drugs treated as generic), either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$1.20 copay; or</li> <li>• \$2.65 copay</li> </ul> For all other drugs, either: <ul style="list-style-type: none"> <li>• \$0 copay; or</li> <li>• \$3.60 copay; or</li> <li>• \$6.60 copay.</li> </ul>	<b>Not Offered</b>	<b>Not Offered</b>

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.

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<b>Catastrophic Coverage</b>	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach \$4,700, you pay nothing for all drugs.
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## **ADDITIONAL INFORMATION SECTION**

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Molina Healthcare is an innovative health care leader providing quality care and accessible services in an efficient and caring manner.

Our mission is to provide quality health services to financially vulnerable families and individuals covered by government programs.

- **24-Hour Nurse Advice Line**
- **Additional Smoking and Tobacco Use Cessation Counseling**
- **Health Education**
- **Nutritional Benefit**  
Up to 30-60 minutes of individual telephonic nutritional counseling upon referral.



## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

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### SUMMARY OF MICHIGAN MEDICARE/MEDICAID BENEFITS

*Your state Medicaid program can be reached through the office of the Michigan Department of Community Health*

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 dual eligible coverage, 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 Molina Medicare Options Plus 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.

See previous Summary of Benefits table for a full description of your Molina Medicare Options Plus HMO SNP Plan benefits and cost-sharing responsibilities.

**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.

## **SUMMARY OF MEDICAID-COVERED BENEFITS SECTION**

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### **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 most supplemental benefits provided by Molina Medicare 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 most supplemental benefits provided by Molina Medicare, where you will have a 0% cost-share.

*Note – Preventive wellness exams and most 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 coverage category. If your dual eligible coverage category 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 dual eligible coverage 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. In your state, the Medicaid program can be reached through the office of the Michigan Department of Community Health.*

\*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%.

## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

### 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 Molina Medicare Options Plus 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.

\* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare service.

Benefit	Medicaid	<b>Molina Medicare Options Plus (HMO SNP)</b> <i>See previous Summary of Benefits table for individual benefit details</i>
<b>IMPORTANT INFORMATION</b>		
<b>Premium and Other Important Information</b>	Medicaid assistance with premium payments and cost-share may vary based on your level of Medicaid eligibility.	<b>General</b> \$28.60 monthly plan premium.*  <b>In-Network*</b> \$0 or \$147 per year for in-network services. This amount may change for 2015.  The plan has \$0 deductible for Part D prescription drugs.  \$6,700 out-of-pocket limit for Medicare-covered services.
<b>Doctor and Hospital Choice</b> <i>(For more information, see Emergency Care and Urgently Needed Care.)</i>	You must go to doctors, specialists, and hospitals that accept Medicaid assignment.  No referral required for specialists.	<b>In-Network</b> You must go to network doctors, specialists, and hospitals.  Referral required for network specialists (for certain benefits).
<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

## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

Benefit	Medicaid	<b>Molina Medicare Options Plus (HMO SNP)</b> <i>See previous Summary of Benefits table for individual benefit details</i>
<b>Chiropractic Services</b>	Covered Restrictions may apply	Covered
<b>Dental Services</b>	Covered Restrictions may apply	Covered
<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
<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 for beneficiaries under age 21.  Not covered for beneficiaries age 21 and older.	Covered
<b>Home Health Care</b> <i>(Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</i>	Covered	Covered
<b>Outpatient Care</b>	Covered	Covered

## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

Benefit	Medicaid	Molina Medicare Options Plus (HMO SNP) <i>See previous Summary of Benefits table for individual benefit details</i>
<b>Outpatient Rehabilitation Services</b> <i>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</i>	Covered	Covered
<b>Outpatient Services</b>	Covered	Covered
<b>Outpatient Substance Abuse Care</b>	Covered through Community Mental Health Services program.	Covered
<b>Over-the-Counter Items</b>	Covered Restrictions may apply	Covered
<b>Podiatry Service</b>	Covered Restrictions may apply	Covered
<b>Prosthetic Devices</b> <i>(Includes braces, artificial limbs and eyes, etc.)</i>	Covered	Covered
<b>Transportation</b> <i>(Routine)</i>	Covered	Covered
<b>Urgently Needed Care</b> <i>(This is NOT emergency care, and in most cases, is out of the service area.)</i>	Covered	Covered
<b>Vision Services</b>	Covered Restrictions may apply	Covered
<b>Wellness/Education and other Supplemental Benefit Programs</b>	Covered	Covered

## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

Benefit	Medicaid	<b>Molina Medicare Options Plus (HMO SNP)</b> <i>See previous Summary of Benefits table for individual benefit details</i>
<b>INPATIENT CARE</b>		
<b>Inpatient Hospital Care</b> <i>(Includes Substance Abuse and Rehabilitation Services)</i>	Covered Substance Abuse covered through Community Mental Health program.	Covered
<b>Inpatient Mental Health Care</b>	Covered through Community Mental Health Services program.	Covered
<b>Skilled Nursing Facility (SNF)</b> <i>(In a Medicare-certified skilled nursing facility)</i>	Covered	Covered
<b>PREVENTIVE SERVICES</b>		
<b>Kidney Disease and Conditions</b>	Covered	Covered
<b>Preventive Services</b>	Covered	Covered
<b>HOSPICE</b>		
<b>Hospice</b>	Covered	Covered
<b>PRESCRIPTION DRUG BENEFITS</b>		
<b>Outpatient Prescription Drugs</b>	Covered	Covered*

## SUMMARY OF MEDICAID-COVERED BENEFITS SECTION

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 Molina Medicare Options Plus HMO SNP Plan.

Benefit	Medicaid
<b>ADDITIONAL MEDICAID BENEFITS</b>	
<b>Maternal Infant Health Program</b>	Covered

*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. In your state, the Medicaid program can be reached through the office of the Michigan Department of Community Health.*