Summary of Benefits

California

Riverside (partial), San Bernardino (partial)

2016

Molina Medicare Options
HMO

MOLINA® HEALTHCARE

Member Services (800) 665-0898, TTY/TDD 711
7 days a week, 8 a.m. - 8 p.m. local time

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SUMMARY OF BENEFITS

January 1, 2016 – December 31, 2016

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 (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **Molina Medicare Options (HMO)** 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 (HMO)**
- 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) 665-0898.

Este documento puede estar disponible para personas que no hablan el idioma inglés. Para más información, llámenos al (800) 665-0898.

Things to Know About Molina Medicare Options (HMO)

Hours of Operation

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

Molina Medicare Options (HMO) Phone Numbers and Website

- If you are **a member** of this plan, call toll-free (800) 665-0898.
- 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 (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.
Our service area includes the following counties in California: Riverside* and San Bernardino*.
** denotes partial county*

Which doctors, hospitals, and pharmacies can I use?

Molina Medicare Options (HMO) 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).

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 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.

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

How much is the monthly premium?	$28.60 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$360 per year for Part D prescription drugs except for drugs listed on Tier 1 which are excluded from the deductible.
Is there any limit on how much I will pay for my covered services?	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. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. 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. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

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COVERED MEDICAL AND HOSPITAL BENEFITS

Note:

- Services with a [1] may require Prior Authorization.
- Services with a [2] may require a Referral from your doctor.

OUTPATIENT CARE AND SERVICES	
Acupuncture	Not covered
Ambulance[1]	You pay nothing
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing
Dental Services[1]	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing Dental services: $10 copay for a single office visit that includes: •Cleaning (for up to 2 every year) •Dental x-ray(s) (for up to 1 every year) •Fluoride treatment (for up to 1 every year) •Oral exam (for up to 2 every year) *Deep Cleanings*- 2 quadrants every 24 months* *Fillings* - 4 every yr* *Simple Extractions* - 5 every yr* *Denture Allowance* - $500 max allowance every 3 yrs; limited to a $250 max allowance per denture plate every 3 yrs* *Denture Adjustments* - 2 of 4 every yr* **Only certain dental ADA procedure codes are covered; other limits apply – see your EOC.*
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: You pay nothing Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: You pay nothing *Plan provides disease management programs and nutritional training for diabetics.*
Diagnostic Tests, Lab and Radiology Services, and X-Rays *(Costs for these services may vary based on place of service)*[1,2]	Diagnostic radiology services (such as MRIs, CT scans): You pay nothing Diagnostic tests and procedures: You pay nothing Lab services: You pay nothing Outpatient x-rays: You pay nothing *-continued on the next page*

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	Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing *No Authorization is required for Outpatient Lab Services and Outpatient X-Ray Services.*
Doctor's Office Visits[1,2]	Primary care physician visit: You pay nothing Specialist visit: You pay nothing
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	You pay nothing
Emergency Care	You pay nothing
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing Routine foot care (for up to 12 visit(s) every year): You pay nothing
Hearing Services[1]	Exam to diagnose and treat hearing and balance issues: You pay nothing Routine hearing exam (for up to 1 every year): $0 copay Hearing aid fitting/evaluation (for up to 1 every two years): $0 copay Hearing aid: $0 copay Our plan pays up to $600 every two years for hearing aids.
Home Health Care[1,2]	You pay nothing
Mental Health Care[1]	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. 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. You pay nothing Outpatient group therapy visit: You pay nothing Outpatient individual therapy visit: You pay nothing
Outpatient Rehabilitation[1,2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing *-continued on the next page*

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	Occupational therapy visit: You pay nothing Physical therapy and speech and language therapy visit: You pay nothing
Outpatient Substance Abuse[1]	Group therapy visit: You pay nothing Individual therapy visit: You pay nothing
Outpatient Surgery[1,2]	Ambulatory surgical center: You pay nothing Outpatient hospital: You pay nothing
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: You pay nothing Related medical supplies: You pay nothing
Renal Dialysis	You pay nothing
Transportation	You pay nothing *Transportation could include a sedan, wheelchair equipped vehicle, or stretcher van.* *48 one-way trips to and from plan-approved locations.*
Urgently Needed Services	You pay nothing
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing Routine eye exam (for up to 1 every year): $0 copay Contact lenses: $0 copay Eyeglasses (frames and lenses): $0 copay Eyeglass frames: $0 copay Eyeglass lenses: $0 copay Eyeglasses or contact lenses after cataract surgery: You pay nothing Our plan pays up to $150 every two years for eyewear.
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) *-continued on the next page*

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	• Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • 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.
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. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE	
Inpatient Hospital Care[1]	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. You pay nothing
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. You pay nothing

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PRESCRIPTION DRUG BENEFITS

How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: You pay nothing Other Part B drugs[1]: You pay nothing
Initial Coverage	After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

STANDARD RETAIL COST-SHARING

Tier	One-month Supply	Two-month Supply	Three-month Supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$15	$30	$45
Tier 3 (Preferred Brand)	$47	$94	$141
Tier 4 (Non-Preferred Brand)	$95	$190	$285
Tier 5 (Specialty Tier)	25% of the cost	**Not Offered**	**Not Offered**

STANDARD MAIL ORDER COST-SHARING

Tier	One-month Supply	Two-month Supply	Three-month Supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Generic)	$15	$30	$45
Tier 3 (Preferred Brand)	$47	$94	$141
Tier 4 (Non-Preferred Brand)	$95	$190	$285
Tier 5 (Specialty Tier)	25% of the cost	**Not Offered**	**Not Offered**

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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Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

ADDITIONAL INFORMATION

January 1, 2016 – December 31, 2016

ADDITIONAL PART C BENEFITS	
What You Pay For These Additional Part C Benefits	You pay nothing.
24-Hour Nurse Advice Line	Available 24 hours a day, 7 days a week.
Additional Smoking and Tobacco Use Cessation Counseling	8 Visits offered in addition to Medicare.
Health Education	
Outpatient Blood Services	3-Pint deductible waived.
Nutritional/Dietary Benefit	12 Individual or group sessions every year. 30-60 minutes of individual telephonic nutritional counseling upon referral.
Worldwide Emergency/Urgent Coverage	Up to $10,000 of worldwide emergency/urgent coverage every year.

See your Evidence of Coverage for more information.

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