

Healthy Advantage HMO SNP Annual Notice of Changes for 2012

This booklet tells you how your Medicare benefits will change next year if you stay in Healthy Advantage HMO SNP. These changes will take effect on January 1, 2012 if you stay in this plan.

To decide what's best for you, compare this information with the benefits of other Medicare health plans in your area, as well as the benefits and costs of Original Medicare.

This plan, Healthy Advantage HMO SNP, is offered by Molina Healthcare of Utah. (When this Annual Notice of Changes says "we," "us," or "our," it means Molina Healthcare of Utah. When it says "plan" or "our plan," it means Healthy Advantage 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 1-877-644-0344 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: 1-877-644-0344. (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.

Annual Notice of Changes for 2012

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Section 1. Important things to know

You are currently enrolled in Healthy Advantage HMO SNP, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are currently enrolled as a member of Healthy Advantage HMO SNP. This plan is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Healthy Advantage HMO SNP is designed specifically for people who have Medicare and 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 that are not usually covered under Medicare. You will also receive Extra Help from Medicare to pay for the costs of your Medicare prescription drugs. Healthy Advantage 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.

Healthy Advantage 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 Utah Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

If you stay enrolled in Healthy Advantage HMO SNP for 2012, there will be some changes to your benefits

Each year, Medicare health plans may decide to change the premiums, cost-sharing amounts, and benefits they offer. These changes may include increasing or decreasing premiums, increasing or decreasing cost-sharing amounts, and adding or subtracting benefits.

We’re sending you this Annual Notice of Changes to tell you how your Medicare benefits as a member of Healthy Advantage HMO SNP will change next year from your current benefits. The changes will take effect on January 1, 2012. Medicare has approved these changes.

This Annual Notice of Changes is only a summary

This Annual Notice of Changes gives you a summary of the changes in your Medicare benefits in 2012. This notice is a brief summary, not a comprehensive description of benefits. For more information, contact the plan or look in your Evidence of Coverage.

- To get the details, you can look in the 2012 Evidence of Coverage for Healthy Advantage HMO SNP. The Evidence of Coverage is the legal, detailed description of your Medicare benefits for 2012. It explains your rights and the rules you need to follow to get your covered services and prescription drugs. (We have included a copy of the Evidence of Coverage in the same booklet with this Annual Notice of Changes. If you have questions or need more information, you can always call Member Services at 1-877-644-0344 (TTY only, call 1-800-346-4128). Hours are Monday through Sunday 8:00 AM to 8:00 PM, local time and calls to these numbers are free.

What should you do?

We want you to know what’s ahead for next year, so **please read the rest of this document very soon to see how the changes in Medicare benefits will affect you if you stay enrolled in Healthy Advantage HMO SNP for 2012.** If you make a change, your new coverage will start on January 1, 2012.

To decide what’s best for you, compare this information about the 2012 benefits for Healthy Advantage HMO SNP to what your benefits and costs would be if you switched to a different Medicare health plan or to Original Medicare.

Section 1. Important things to know

If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website at <http://www.medicare.gov>. The Plan Finder helps you compare your choices by giving you information about plans' benefits and costs and showing you how Medicare rates the plans. For example, these ratings let you compare how well plans are doing in different categories that include detecting and preventing illness, member satisfaction, and customer service. (To view the information about plans, go to <http://www.medicare.gov>. Click on the "Health & Drug Plans" button on the left and then choose "Compare Drug and Health Plans.") If you want us to mail you a copy of the ratings for Healthy Advantage HMO SNP that are shown on the Medicare website, please call us at 1-877-644-0344 Monday through Sunday 8:00 AM to 8:00 PM, local time. TTY/TDD users call 1-800-346-4128.

To get information about Original Medicare and about Medicare plans available in your area, you can also call Medicare or your State Health Insurance Assistance Program. For numbers to call, see Section 7 of this Annual Notice of Changes.

We value your membership in Healthy Advantage HMO SNP and hope to keep you as a member. But if you want to make a change for 2012, see "When can you change to a different plan?" in Section 6 for time periods when you can make a change.

There are programs to help people with limited resources pay for their prescription drugs

Because you get assistance from Medicaid, you get "**Extra Help**" from Medicare to pay for your prescription drugs. The Extra Help program is also called the "low-income subsidy" or LIS. People whose yearly income and resources are below certain limits can qualify for this help. To learn more about the Extra Help program, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. You can also look in Section III of the Medicare & You 2012 Handbook or call your State Health Insurance Assistance Program (the name and phone numbers for this organization are on the back cover of this booklet).

How can you get information about your drug costs under the Extra Help program?

You receive Extra Help from Medicare to pay for your prescription drugs. Because you have Extra Help, 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 2. Changes to your monthly premium

	2011 (this year)	2012 (next year)
Monthly premium	\$0 (You must continue to pay your Medicare Part B premium, unless it is paid by Medicaid or another third-party.)	\$0 (You must continue to pay your Medicare Part B premium, unless it is paid by Medicaid or another third-party.)

Section 3. Medical services: Changes to your benefits and cost sharing (“out-of-pocket” costs)

Changes to your benefits

As shown below, Healthy Advantage HMO SNP is changing our covered benefits for next year. For details, see Chapters 3 and 4 in your Evidence of Coverage.

	2011 (this year) Medicare-covered benefits only	2012 (next year) Medicare-covered benefits only
Podiatry / Routine Foot Care	Covered	Not Covered
Over the Counter(OTC)	Not covered	Covered \$20 monthly allowance
Transportation	Covered 20 one way trips	Covered 12 one way trips
Preventive Dental (Visit maximum)	Covered Unlimited	Covered 2 per year
Comprehensive Dental (Comprehensive Dental, Emergency Svcs, Diagnostic Svcs, Restorative Svcs, Endodontics / Periodontics / Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery)	Covered \$1200 Comprehensive coverage	Covered \$1000 Comprehensive coverage 0% - 50% coinsurance
Dentures	Not Covered	Covered Under Comprehensive Dental
Dental X-Rays	Covered 2 dental x-rays	Covered 2 bitewing x-rays per year 1 full mouth x-ray per year

Changes to your cost sharing (“out-of-pocket” costs)

You do not have “out-of-pocket” costs for covered services. You pay nothing for medical services covered by Healthy Advantage HMO SNP.

Section 4.

Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

Changes to the List of Covered Drugs (Formulary)

Healthy Advantage HMO SNP has a “List of Covered Drugs (Formulary)” – or “Drug List” for short. It tells which Part D prescription drugs are covered by the plan. (Chapter 5, Section 1.1 of your Evidence of Coverage explains about Part D drugs.)

We may make changes to the plan’s Drug List from time to time throughout the year. In addition, there are a number of changes to the Drug List that will take effect on January 1, 2012. Changes to the plan’s Drug List have been approved by Medicare.

- **We have added some new drugs to the list and removed others.** We have added some new drugs that became available. We have replaced some brand name drugs with new generic drugs. We have replaced some expensive drugs with less costly drugs that have been shown to work just as well or better. We have removed a few drugs due to safety concerns or because medical research has shown they are not effective.
- **We have added some new restrictions to certain drugs, and reduced the restrictions on others.** Restrictions can include a requirement to get plan approval in advance or to try a different drug first to see how well it works. Restrictions can also include limits on the quantity of the drug that the plan will cover for you.
 - 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.

Please check to see if any of these changes to drug coverage affect the drugs you use.

- You can look for your drugs on the Drug List we sent with this Annual Notice of Changes. If you can’t find some of your drugs on this Drug List, you can call Member Services for help finding your drugs.

Changes to your “out-of-pocket” costs

Every drug on the plan’s Drug List is in one of four (4) cost-sharing tiers. Medicare allows us to **change what you pay for a drug in each cost-sharing tier** only once a year. The changes shown below will take effect on January 1, 2012, and stay the same for the entire plan year.

Besides the changes to copayments and coinsurance you see below, there is another change that could affect what you pay for your drugs next year. **We have moved some of the drugs on the Drug List to a different cost-sharing tier.** Some drugs will be in a lower cost-sharing tier, others will be in a higher cost-sharing tier. To see if any of your drugs have been moved to a different cost-sharing tier, look them up on the Drug List.

Changes to what you pay for your drugs during the Initial Coverage Stage

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).

The chart below summarizes changes to what you will pay as your share of the cost of covered prescription drugs when you are in the Initial Coverage Stage. These changes affect Part D prescription drugs only.

Section 4.

Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

The costs in the chart are for prescriptions filled at network, retail pharmacies. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. There may be restrictions for prescriptions filled at out-of-network pharmacies, such as a limit on the amount of the drug you can receive. See Chapter 5, Section 3.5 of the Evidence of Coverage for more information.

	2011 (this year)	2012 (next year)
Drugs in Cost-Sharing Tier 1 Generic Brand For a one-month (31-day) supply of a drug in cost-sharing tier 1 that is filled at a network pharmacy	For copayments: You pay \$0, \$1.10 or \$2.50 per prescription.	For copayments: You pay \$0, \$1.10 or \$2.60 per prescription.
Drugs in Cost-Sharing Tier 2 Preferred Brand For a one-month (31-day) supply of a drug in cost-sharing tier 2 that is filled at a network pharmacy	For copayments: You pay \$0, \$3.30 or \$6.30 per prescription.	For copayments: You pay \$0, \$3.30 or \$6.50 per prescription.
Drugs in Cost-Sharing Tier 3 Non-Preferred Brand For a one-month (31-day) supply of a drug in cost-sharing tier 3 that is filled at a network pharmacy	For copayments: You pay \$0, \$3.30 or \$6.30 per prescription.	For copayments: You pay \$0, \$3.30 or \$6.50 per prescription.
Drugs in Cost-Sharing Tier 4 Specialty Brand For a one-month (31-day) supply of a drug in cost-sharing tier 4 that is filled at a network pharmacy	For copayments: You pay \$0, \$3.30 or \$6.30 per prescription.	For copayments: You pay \$0, \$3.30 or \$6.50 per prescription.

Section 4. Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

Changes to the plan’s Drug Payment Stages

The chart below summarizes changes to the plan’s Drug Payment Stages. These changes affect Part D prescription drugs only.

	2011 (this year)	2012 (next year)
<p>Yearly Deductible Stage During the Yearly Deductible Stage, you (or others on your behalf) pay the full cost of your tiers 2 - 4 drugs until you reach the plan’s deductible amount. Once you meet your deductible, you move on to the Initial Coverage Stage.</p>	<p>\$310 This is how much you (or others on your behalf) must pay for your tiers 2 - 4 drugs before the plan will pay its share.</p>	<p>\$320 This is how much you (or others on your behalf) must pay for your tiers 2 - 4 drugs before the plan will pay its share.</p>
<p>Initial Coverage Stage During the Initial Coverage Stage, the plan pays its share of the cost of your covered drugs, and you pay your share. (Changes to your share of the costs are described in the previous chart.) You stay in this stage until your year-to-date “total drug costs” total \$2,930 of your Part D drugs reaches the limit for the Initial Coverage Stage. Once you reach this limit, you move on to the Coverage Gap Stage.</p>	<p>\$2,840 When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage.</p>	<p>\$2,930 When the total costs for your Part D drugs reaches this amount, you move on to the Coverage Gap Stage.</p>
<p>Coverage Gap Stage You stay in the Coverage Gap Stage until your out-of-pocket costs for your Part D drugs reaches the amount that qualifies you for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 93% of the price for generic drugs. You stay in this stage until your out-of-pocket costs reach: \$4,550 This is the amount you (or others on your behalf) must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>	<p>During the Coverage Gap Stage, you pay 50% of the price (plus the dispensing fee) for brand name drugs and 86% of the price for generic drugs. You stay in this stage until your out-of-pocket costs reach: \$4,700 This is the amount you (or others on your behalf) must pay out-of-pocket to leave the Coverage Gap Stage and qualify for Catastrophic Coverage.</p>
<p>Catastrophic Coverage Stage During the Catastrophic Coverage Stage, the plan will pay most of the cost for your Part D drugs. You will stay in this stage until the end of the calendar year.</p>	<p>5% of the drug cost or \$2.50 for generic drugs and \$6.30 for branded drugs, whichever is greater.</p>	<p>5% of the drug cost or \$2.60 for generic drugs and \$6.50 for branded drugs, whichever is greater.</p>

Section 4.

Part D prescription drugs: Changes to your benefits and “out-of-pocket” costs

What if changes for 2012 affect drugs you are taking now?

What if a drug you are taking now is not on the Drug List for 2012? What if it has been moved to a higher cost-sharing tier? What if a new restriction has been added to the coverage for this drug? If you are in any of these situations, here’s what you can do:

- In some situations, the plan will cover a **one-time, temporary supply** of your drug when your current supply runs out. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. Chapter 5, Section 6.2 of the Evidence of Coverage explains when you can get a temporary supply and how to ask for one.

Meanwhile, you and your doctor will need to decide what to do before your temporary supply of the drug runs out.

- **Perhaps you can find 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 doctor to find a covered drug that might work for you.
- **You and your doctor can ask the plan to make an exception for you** and cover the drug. You can ask for an exception in advance for next year and we will give you an answer to your request before the change takes effect. To learn what you must do to ask for an exception, see the Evidence of Coverage that was included in the mailing with this Annual Notice of Changes. Look for Chapter 9 of the Evidence of Coverage (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

Section 5.

What about changes to the plan's network of providers?

Will your doctors and other providers still be in the plan's network next year?

There are changes to the network of providers for 2012. In addition, it's possible for the network of plan providers to change at any time during the year.

- **Please check with your doctors and other providers you currently use** to make sure they will continue to be part of the provider network for Healthy Advantage HMO SNP in 2012.
- For the most up-to-date information on the network of providers, check our website www.molinamedicare.com) or call Member Services (see phone numbers on the back cover of this booklet).

Section 6.

Do you want to stay in the plan or make a change?

Do you want to stay with Healthy Advantage HMO SNP?

If you want to keep your membership in Healthy Advantage HMO SNP for 2012, it's easy. You don't need to tell us or fill out any paperwork. **You will automatically remain enrolled as a member if you do not sign up for a different plan or Original Medicare.**

Do you want to make a change?

If you decide to leave Healthy Advantage HMO SNP, you can switch to a different Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan). If you switch to a different plan or to Original Medicare, you will continue to get the assistance from Medicaid that you are entitled to.

If you want to change to a different plan, there are many choices. If you have access to the Internet, you can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on the "Health & Drug Plans" button on the left. Then choose "Compare Drug and Health Plans.") You can also get information about plans from Medicare or from your State Health Insurance Assistance Program. (For numbers to call, see Section 7 of this Annual Notice of Changes.) As a reminder, Molina Healthcare of Utah offers other Medicare health plans in addition to the plan you are now enrolled in. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

When can you change to a different plan?

You can change your Medicare coverage **at any time**. You can change to another Medicare health plan (either with or without Medicare prescription drug coverage) or you can cancel your plan enrollment and switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time. Your new coverage will start on the first day of the month after you request the change.

How do you make a change?

See Chapter 10 of the Evidence of Coverage. It tells what you need to do to make a change from Healthy Advantage HMO SNP to 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.

Section 6. Do you want to stay in the plan or make a change?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. <p>You will automatically be disenrolled from Healthy Advantage HMO SNP when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> • Original Medicare with a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. <p>You will automatically be disenrolled from Healthy Advantage HMO SNP when your new plan's coverage begins.</p>
<ul style="list-style-type: none"> • Original Medicare without a separate Medicare prescription drug plan. <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet). • You can also contact Medicare, 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. • You will be disenrolled from Healthy Advantage HMO SNP when your coverage in Original Medicare begins.

Section 7.

Do you need some help? Would you like more information?

We have information and answers for you

To learn more, read the information we sent in the same package with this Annual Notice of Changes. This includes a copy of the Evidence of Coverage and a copy of the List of Covered Drugs (Formulary).

If you have any questions, we are here to help. Please call our Member Services at 1-877-644-0344 (TTY/TDD only, call 1-800-346-4128). We are available for phone calls Monday through Sunday, 8:00 AM to 8:00 PM, local time. Calls to these numbers are free.

You can get help and information from your State Health Insurance Assistance Program (SHIP)

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

Health Insurance Information Program (HIIP) 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. Health Insurance Information Program (HIIP) counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call Health Insurance Information Program (HIIP) at 1-800-541-7735.

You can get help and information from Medicare

Here are three ways to get information directly from Medicare:

- **Call 1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **Visit the Medicare website (<http://www.medicare.gov>)**.
- **Read Medicare & You 2012 Handbook.** Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or 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.

You can get help and information from Medicaid

Utah Department of Health (Utah's Medicaid program)	
CALL	1-800-662-9651
TTY/TDD	711
WRITE	PO Box 143108 Salt Lake City, Utah 84114-3108
WEBSITE	health.utah.gov/Medicaid/