

Benefits

BENEFIT DESCRIPTIONS

Covered Benefits

As a Member, you are entitled to receive Program Covered Benefits subject to all the terms, conditions, exclusions, and limitations described in this Member Service Guide.

Program Covered Benefits are described in the sections below and must be:

1. Medically Necessary
2. Specifically described in this Member Handbook
3. Provided by Plan Providers
4. Prescribed by a Plan Physician (except for Emergency Services) and when required, Authorized in advance by your PCP; or
5. Part of a treatment plan for covered services or required to treat medical conditions which are direct and predictable complications or consequences of Covered Benefits.

A full listing of exclusions and limitations to the Program can be found in the section entitled “What is Not Covered.” Please refer to that section to ensure a full understanding of the Covered Benefits under this plan.

Alcohol and Drug Abuse

Inpatient: Covered Benefits are limited to Emergency hospitalization as Medically Necessary to remove toxic substances from the system.

Outpatient: Crisis intervention and treatment of alcoholism or drug abuse is covered, as Medically Necessary, for up to a maximum of 20 visits per Benefit Year.

Blood and Blood Products

Costs of processing, storage, and administration of blood and blood products, including autologous blood, are covered when medically necessary. Blood and blood products are covered as ordered by a Plan Physician in inpatient and outpatient settings.

Cataract Spectacles and Lenses

Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered. One pair of conventional eyeglasses or conventional contact lenses is covered if Medically Necessary after cataract surgery with insertion of an intraocular lens.

Cancer Clinical Trials

Routine health care services associated with

a Member's participation in an eligible cancer clinical trial are covered.

Covered services include the following:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision and clinically appropriate monitoring of the investigational drug, item, device, or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service.

To be eligible for coverage, the Member must meet the following requirements:

- The Member must be diagnosed with cancer.
- The Member must be accepted into a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer.
- The Member's Plan Physician must recommend participation in the clinical trial based on his/her determination

that participation in the clinical trial will have a meaningful potential benefit to the Member.

The cancer clinical trial must meet the following requirements:

- The trial's endpoints must not be defined exclusively to test toxicity.
- The trial must have a therapeutic intent.
- The treatment provided in the clinical trial must either: 1) Be approved by one of the National Institutes of Health, the federal Food and Drug Administration, the United States Department of Defense, or the United States Veterans' Administration, or 2) Involve a drug that is exempt under federal regulations for a new drug application.

Please note that if a clinical trial is conducted by a doctor who does not participate in the Plan's provider network, he/she may hold the Member responsible to pay for services that are billed above the Plan's normally contracted rates.

Diabetes Treatment

Supplies, equipment and services for the treatment and/or control of diabetes are covered (even when available without a

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prescription), including:

1. Blood glucose monitors and testing strips
2. Blood glucose monitors designed for the visually impaired
3. Insulin pumps and all related necessary supplies
4. Ketone urine testing strips
5. Lancets and lancet puncture devices
6. Pen delivery systems for the administration of insulin
7. Podiatric devices to prevent or treat diabetes-related complication
8. Insulin syringes
9. Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin
10. Self-management training, education, and medical nutrition therapy
11. Laboratory tests appropriate for the management of diabetes
12. Dilated retinal eye exams
13. Insulin, glucagon and other prescriptive medications for the treatment of diabetes

Diagnostic X-ray and Laboratory Services

- Electrocardiography

- Electroencephalography
- Mammography for screening or diagnostic purposes
- Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin)
- Other services (including follow-up care) necessary to appropriately evaluate, diagnose and treat a Member's illness or injury

Disposable Medical Supplies

Disposable medical supplies are medical supplies that are consumable or expendable in nature and cannot withstand repeated use or use by more than one individual, such as bandages, support hose and garments, elastic bandages and incontinence pads. Disposable medical supplies are only covered when provided in a hospital or physician office or by a home health professional.

Durable Medical Equipment (DME)

DME is covered. Molina Healthcare reserves the right to determine if the DME will be purchased or rented. DME is a physical accessory designed to serve a repeated medical purpose and appropriate for use in the Member's home. DME that is primarily

for the convenience of the Member or caretaker is not considered Medically Necessary.

DME is limited to equipment and devices which are:

1. intended for repeated use over a prolonged period;
2. not considered disposable, with the exception of ostomy bags;
3. ordered by a licensed health care provider acting within the scope of his or her license;
4. intended for exclusive use by the Member;
5. not duplicative of the function of another piece of equipment or device already covered for the Member;
6. generally not useful to a person in the absence of illness or injury;
7. primarily serving a medical purpose; and
8. appropriate for use in the home.

Medically Necessary repair or replacement of DME is covered when prescribed by a Plan Physician or ordered by a licensed health care provider acting within the scope of his or her license, and when not caused by misuse or loss.

Emergency Services

Hospital emergency room services provided

inside or outside the Service Area, which are Medically Necessary for treatment of an Emergency Medical Condition, are covered.

Family Planning

Program benefits include:

1. Counseling
2. Surgical procedures for sterilization as permitted by state and federal law
3. Diaphragms, and coverage for other FDA-approved devices
4. Emergency contraception when dispensed by a Plan Pharmacy, or when dispensed by a non- Plan Provider in the event of a medical emergency.
5. Interruption of pregnancy (abortion) services.

Pregnancy terminations

Abortions are legal in California. Abortions are fully paid by Molina Healthcare. You do not need to get prior “authorization” or approval. Most abortions are done in a few hours and you will not need to stay in the hospital. If you must stay in the hospital you will need to get approval (prior authorization). This approval is not for the abortion. The approval is simply for the hospital stay. Abortion services include the use of Mifepristone (mifepres), commonly known as RU-486.

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For information on Family Planning Services available to you in your area, other than Molina Healthcare, call the State Department of Health Care Services, Office of Family Planning, at 1 (800) 942-1054 for assistance.

Health Education Services

Effective, health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by the Plan or health care organizations affiliated with the Plan. Health education services include services related to tobacco use and drug and alcohol abuse.

Health education services relating to tobacco use means tobacco use prevention and education services including tobacco use cessation services, in accordance with protocols established by the board in coordination with the Tobacco Control Section of the State Department of Health Care Services.

Call Molina Healthcare's Member Services Department for additional information on class descriptions, dates, times and locations.

Health Facilities

A. Inpatient Hospital Services

- General hospital services
- Semi-private room with customary furnishings and equipment
- Private rooms (when Authorized as Medically Necessary)
- Meals (including special diets when Authorized as Medically Necessary)
- Use of operating room and related facilities
- General nursing care
- Ancillary services
- Intensive care unit and services
- Drugs, medications and biologicals
- Anesthesia and oxygen
- Diagnostic laboratory and x-ray services
- Special duty nursing (when Authorized as Medically Necessary)
- Physical, occupational and speech therapy
- Respiratory therapy
- Administration of blood and blood products
- Other diagnostic, therapeutic and rehabilitative services as appropriate
- Coordinated discharge planning

including planning of continuing care, as necessary

B. Outpatient Hospital Services

- Diagnostic, therapeutic and surgical services
- Physical, occupational and speech therapy
- Related services and supplies in connection with these services
- Operating room and treatment room
- Ancillary services
- Medications that are supplied by the Plan Hospital or Plan Facility for use during a Member's stay at the facility

Home Health Agency Services

Home health services are services provided at the home of the Member and provided by a Plan Provider or other Authorized health care professional operating within the scope of his/her license. This includes visits by registered nurses, licensed vocational nurses, and home health aides for physical, occupational, speech, and respiratory therapy when prescribed by a Plan Provider acting within the scope of his/her licensure. The following home health agency services are covered when Medically Necessary and prescribed or directed by a Plan Physician. Visits on an intermittent basis to the Member for the usual and customary time

required to perform the particular skilled service(s), including diagnostic and treatment services, during each visit for the following services:

- Skilled nursing services of a registered nurse, public health nurse, licensed vocational nurse, and/or licensed home health aide;
- Rehabilitation, physical, occupational and speech therapy services as Medically Necessary;
- Home health aide services, consisting primarily of caring for the Member and furnished by appropriately trained personnel functioning as employees of, or under arrangements with, a Plan home health agency. Such home health aide services will be provided only when the Member is receiving the services specified above and only when such home health aide services are ordered by a physician and supervised by a registered nurse, as the professional coordinator employed by a Plan home health agency;
- Medical social service consultations provided by a qualified medical social worker;
- Medical supplies, medicines, and laboratory services, when provided by a home health agency at the time services are rendered;
- Drugs and medicines prescribed by a

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Plan Physician and related pharmaceutical services, and laboratory services to the extent they would be covered under the Plan if the Member were in the hospital;

- Home health services are limited to those services that are prescribed or directed by the Plan Physician or other appropriate authority designated by the Plan;
- Physical, occupational and speech therapy are limited to the terms and conditions described under the “Physical, Occupational and Speech Therapy” benefit described in this section.

Hospice Services

Hospice Services are covered for those Members who have been diagnosed with a terminal illness and have a life expectancy of twelve months or less, and who elect hospice care for the illness instead of restorative services covered by the Plan. Covered Benefits are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

Covered Benefits include:

1. Nursing care
2. Medical social services

3. Home health aide services, skilled nursing services, and homemaker services under the supervision of a qualified registered nurse
4. Physician services
5. Drugs
6. Pharmaceuticals, Medical equipment and supplies
7. Counseling and Social services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, will also be provided when needed.
8. Bereavement services
9. Physical, occupational and speech therapy as described in this section for short-term inpatient care, pain control and symptom management or to enable the Member to maintain activities of daily living and basic functional skills.
10. Interdisciplinary team care with development and maintenance of an appropriate plan of care.
11. Medical direction as needed to meet the general medical needs of the Member to the extent that these needs are not met by the attending physician.
12. Volunteer services
13. Short-term inpatient care arrangements.

Special Coverage:

1. Periods of Crisis:

Nursing care services are covered on a continuous basis for 24 hours a day during periods of crisis as necessary to maintain a Member at home.

Hospitalization is covered when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

2. Respite Care:

Respite care is short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member. Coverage of respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Maternity Care

Medically Necessary professional and hospital services relating to maternity care

is covered, including: prenatal and postnatal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized; and participation in the statewide prenatal testing program administered by the State Department of Health Care Services known as the Expanded Alpha Feto Protein Program.

Inpatient hospital care will be covered for no less than forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) hours following a delivery by cesarean section. The mother, in consultation with the treating physician, may decide to be discharged before the 48 or 96 hour time period. Extended stays beyond the 48 or 96 hour time period must be Authorized by the Plan.

The Plan will also cover a follow-up visit within 48 hours of discharge when prescribed by the treating physician. The visit shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician, in consultation with the mother, shall determine whether the post discharge visit shall occur at the home, at the hospital, or at the treating physician's office after assessment of the environmental and social risks, and the transportation needs of the family.

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Medical Transportation Services

Program Covered Benefits include emergency ambulance transportation in connection with emergency services to the nearest Plan Hospital. This includes ambulance and ambulance transport services provided through the “911” emergency response system. Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility, or facility to home is covered when it is:

1. Medically Necessary, or
2. Requested by a Plan Provider, or
3. Authorized in advance by the Plan.

Mental Health Services

Inpatient Mental Health Care Services

Cost to Member: No copayment

Description

Mental health care in a participating hospital when ordered and performed by a participating mental health professional.

Basic Mental Health Services (Provided by Molina Healthcare or Molina Healthcare sub-contractor).

Diagnosis and treatment of a mental health condition. Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).

Limitations

Basic mental health care services are limited to thirty (30) days per benefit year.

Substitution days may be authorized by Molina Healthcare. Molina Healthcare, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following:

- 2 days of residential treatment,
- 3 days of day care treatment, or
- 4 outpatient visits.

Severe Mental Illness (SMI)

Inpatient mental health care services for the treatment of Severe Mental Illnesses. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Limitations

Unlimited days.

Serious Emotional Disturbance (SED) Services

Diagnosis and treatment of SED conditions. Inpatient mental health care services for the treatment of a Serious Emotional Disturbance.

Examples of SED symptoms include, but are not limited to:

- Serious problem eating or sleeping
- Often crying or sad

- Saying things that worry you
- Behaving in ways that cause serious family and school problems
- Ongoing or frequent problems with friends
- Purposefully hurting him/herself and others

Limitations

Unlimited days.

Outpatient Mental Health Care Services

Cost to Member: No Copayment

Description

Mental health care services when ordered and performed by a participating Molina Healthcare mental health provider. These services require prior authorization.

For the AIM Program in San Diego County, behavioral healthcare services are provided through Psychiatric Centers of San Diego (Behavioral Health Care), a contracted, delegated Managed Behavioral Health Organization.

Behavioral Health Care

Phone: (619) 528-4600

Fax: (619) 528-4625

Hrs: 9:00AM-5:00PM (Monday-Friday)

Basic Mental Health Care Services

- Services for illnesses that do not meet the criteria for Severe Mental Illness (SMI) or Serious Emotional Disturbance (SED).
- This includes, but is not limited to, treatment for members who have experienced family dysfunction or trauma,

including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.

- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the member

Limitations

Basic mental health care outpatient services are limited to twenty (20) visits per benefit year, except that the number of treatment days may be increased when outpatient treatment days are substituted for inpatient hospitalization days as described in the Inpatient Mental Health Services benefit description section of this Evidence of Coverage (EOC) booklet.

Severe Mental Illness (SMI)

Outpatient mental health care services for the treatment of severe mental illnesses. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Limitations

Unlimited visits.

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Serious Emotional Disturbance (SED) Services

Diagnosis and treatment of SED conditions. Outpatient mental health care services for the treatment of a Serious Emotional Disturbance. Examples of SED symptoms include, but are not limited to:

- Serious problem eating or sleeping
- Often crying or sad
- Saying things that worry you
- Behaving in ways that cause serious family and school problems
- Ongoing or frequent problems with friends
- Purposefully hurting him/herself and others

Limitations

Unlimited visits.

Nutrition Services

Direct patient care nutrition services, including nutritional assessment, are covered.

Paramedic Ambulance/Medical Transportation Services

Medical transportation services provided in connection with the following are covered.

1. Emergency Services.
2. A Plan Authorized transfer of a Member to a Plan Hospital or Plan skilled nursing facility.

Asthma

The following items are covered when medically necessary for the management and treatment of asthma:

1. inhaler spacers
2. nebulizers, including face masks and tubing
3. peak flow meters
4. education on asthma, including instruction on the proper use of these devices

Phenylketonuria

The diagnosis and treatment of phenylketonuria are covered as follows:

1. Medically Necessary formulas and special food products prescribed by a Plan Physician, to the extent that the cost of these items exceeds the cost of a normal diet.
2. Consultation with a physician who specializes in the treatment of metabolic diseases.

Physical, Occupational and Speech Therapy

The services of physical, occupational, and speech therapists are covered when Medically Necessary. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. The Plan will require periodic evaluations as long as Medically Necessary therapy is provided.

Prescription Drugs

Following are Covered Benefits:

- Medically Necessary drugs when

prescribed by a Plan Physician acting within the scope of his/her licensure and obtained through a Plan Pharmacy. Outpatient prescription drugs that are not obtained from a Plan Pharmacy are not covered and you will be responsible for payment, except in cases of Emergency services or out of area Urgent Care Services.

- Prenatal vitamins and fluoride supplements, included with vitamins or independent of vitamins, which require a prescription.
- Medically Necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a Plan Physician in connection with a covered service and obtained through a Plan Pharmacy.
- One cycle or course of treatment of tobacco cessation drugs per Benefit Year, provided the Member attends tobacco use cessation classes or programs in conjunction with the tobacco cessation drugs.
- All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices.
- Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol

prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term “disposable” includes devices that may be used more than once before disposal.

Molina Healthcare uses a Drug Formulary. This is a continuously updated list of medicines for Plan Physicians to use when prescribing medicines for you. A Drug Formulary enhances quality of care by encouraging the use of those prescription medications that are demonstrated to be safe and effective, and produce superior patient outcomes. Molina Healthcare’s Pharmacy and Therapeutics Committee, composed of Plan Providers and Pharmacists, meets quarterly to evaluate the Formulary and ensure that it is as useful and effective as possible. The Committee considers newly developed drugs, frequently requested non-Formulary drugs, and recommendations from Plan Members, Providers, and Pharmacists for possible addition to the Formulary. Medications that are not listed on the Drug Formulary are not covered, unless approved by the Plan. Before going to the pharmacy, ask your doctor to check whether the prescription is included on the Drug Formulary.

Prescription drugs must be dispensed in generic form when one is available, provided that no medical contraindications exist. Members have access to brand name drugs,

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when Medically Necessary, with Prior Authorization and the treating physician issues a prescription indicating “do not substitute” or “prescribe as written.”

In some cases, physicians may prescribe medications that are not on the Drug Formulary. In these instances, the physician contacts the Plan to request Authorization. The Plan reviews all non-Formulary requests within 24-hours (one business day). The Plan will work with the physician to provide non-Formulary drugs when they are Medically Necessary. If the Plan denies your physician’s request to cover a non-Formulary medication, you may appeal the decision through the Plan’s Grievance Process.

Molina Healthcare has specified certain medications as “maintenance drugs,” which are generally used in treating chronic or long-term illnesses. These drugs are specifically designated as maintenance drugs in the Drug Formulary. Maintenance drugs are available for up to a 90-day supply through mail order or through retail Plan Pharmacies.

If you have any questions regarding a prescription, such as whether or not the drug(s) prescribed are available on the Drug Formulary, please call our Member Services Department. Remember that the Formulary is a tool for your doctor to use when determining the most appropriate course of treatment. The presence of a drug on the

Formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Professional Services

The following services (provided by a physician or other licensed health professional) are covered:

Professional services and consultations by a Plan Physician or other licensed health care provider acting within the scope of his/her license are covered, including the following:

- Surgery and assistant surgery
- Anesthesia (inpatient and outpatient)
- Inpatient hospital and skilled nursing facility visits
- Professional office visits, including allergy testing and treatments
- Radiation therapy and chemotherapy
- Dialysis treatment
- Home visits by a physician or nurse when Authorized as Medically Necessary
- All generally accepted cancer screening tests as determined by the United States Preventive Services Task Force, including the conventional Pap test and, upon the referral of the Member’s PCP, the option of any cervical cancer screening test approved by the federal

Food and Drug Administration (FDA).

- A. **Eye Examinations:** Eye refractions to determine the need for corrective lenses and dilated retinal eye exams.
- B. **Hearing Tests, Hearing Aids and Services:** Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Monaural or binaural hearing aids, including ear molds, the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provisions of a covered hearing aid.
- C. **Immunizations for Adults:**
 Immunizations for adults as recommended by the AICP.
 Immunizations required for travel as recommended by the ACIP.
 Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.
- D. **Periodic Health Examinations for Adults:** Periodic health examinations including all routine and diagnostic testing, Human Immunodeficiency Virus (HIV) testing and laboratory services appropriate for such examinations.

Prosthetics and Orthotics

Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Reconstructive Surgical Services

Plastic and reconstructive surgical services are covered only as described below:

- Reconstructive surgical services following a mastectomy or lymph node dissection are covered. The length of a hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. There is no prior approval required from the Plan in determining the length of hospital stay following these procedures. Members who elect to have breast reconstruction after a mastectomy are covered for all

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complications of the mastectomy and reconstructive surgery, prostheses for a reconstruction of the affected breast, and reconstructive surgery on the other breast as may be needed to produce a symmetrical appearance.

- Medically Necessary reconstructive services performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, are covered when performed to improve function, create a normal appearance to the extent possible; or restore and achieve symmetry incident to mastectomy. Services for this purpose include reconstructive surgery and associated procedures following a mastectomy and breast prosthesis required incidental to the surgery.

Skilled Nursing Facility Services

- Skilled nursing facility services are covered when Medically Necessary for up to a maximum of 100 days per Benefit Year.
- Skilled nursing care are those services prescribed by a Plan Provider and provided in a qualified licensed skilled nursing facility when Medically Necessary. Covered Benefits include skilled nursing on a 24-hour basis; bed and board; x-ray and laboratory

procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; and appliances and equipment normally furnished by the skilled nursing facility.

Transplants

Human organ transplant services (non-experimental) are covered. These services include:

- Medically Necessary organ and bone marrow transplants which are not experimental or investigational in nature
- Reasonable professional and hospital expenses for a live donor if the expenses are directly related to the transplant for a Member
- Charges for testing of relatives as potential donors for matching bone marrow or organ transplants
- Charges associated with the search and testing of unrelated bone marrow or organ donors through a recognized Donor Registry
- Charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses directly relate to the anticipated transplant of the Member

These services include professional and

hospital services for a live donor who specifically designates the Member recipient if the services are directly related to the transplant, other than corneal, subject to the following restrictions:

1. Preoperative evaluation, surgery, and follow-up care shall be provided at Plan centers having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care;
2. Patients shall be selected by the patient-selection committee of the Plan facilities and subject to prior Authorization; and
3. Only anti-rejection drugs, biological products, and procedures that have been established as safe and effective, and not experimental or investigational, are covered.

Urgent Care Services

Urgent Care Services means those services performed, inside or outside the Plan's service area, which are medically required within a short timeframe, usually within twenty-four (24) hours, in order to prevent a serious deterioration of a Member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity

services necessary to prevent serious deterioration of the health of the enrollee or the enrollee's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the Plan's service area. Urgent care services received outside the Plan's service area are considered emergency services and do not require PCP authorization.

EXCLUDED BENEFITS

Exclusions and Limitations

The services and supplies listed below are exclusions (not Covered Benefits) or are covered with limitations (Covered Benefits only in specific instances) in addition to those already described in this Member Service Guide. Exclusions include any services or supplies that are:

- a. Not Medically Necessary
- b. Not specifically described in this Member Service Guide
- c. Specified as excluded in this Member Service Guide
- d. In excess of the limits described in this Member Service Guide
- e. Not provided by Plan Providers (except for Emergency or Authorized Urgent Care Services)