



Molina Healthcare of California

**Healthy Families Program
Combined Evidence of Coverage and Disclosure Form**

**ERRATA
Effective November 1, 2009 for the 2009-2010 Benefit Year**

The Healthy Families Program (HFP) has made changes to the program. There are new copayment increases, as of November 1, 2009, for applicable covered benefit services. These changes have been made to your HFP Combined Evidence of Coverage (EOC) and Disclosure Form (DF) for the 2009-2010 benefit year. **The changes are noted by underlined and strike-out text.** Please read these changes and keep this document with the EOC/DF you have received.

If you have any questions regarding the HFP EOC/DF Booklet, please call Molina Healthcare of California's (Molina Healthcare) Member Services Department toll-free at 1 (888) 665-4621, 7am to 7pm, Monday through Friday. If you are deaf or hard of hearing, you may contact our TDD/TTY line at 1 (800) 479-3310 or by dialing the California Relay Service at 711.

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Section: Benefits – What is Covered Under My Child's Plan? (Benefits)

Healthy Families Program Changes
Effective November 1, 2009

Copayments

The HFP has increased copayments for applicable covered services for members who are in Income Categories B & C. This copayment increase does not apply to members in Income Category A. Please refer to page 11 of this document to read more about HFP Income Categories and new definitions that are to be added to the Molina Healthcare EOC.

On the chart below, locate your family size and net income column to find your income category, A, B or C. If your monthly income is below Category A, your children may be eligible for free coverage through the Medi-Cal Program.

Healthy Families Program
Income Categories A, B, and C
Effective April 1, 2009 through March 31, 2010

<u>Family Size</u>	<u>Category A Monthly Income</u>	<u>Category B Monthly Income</u>	<u>Category C Monthly Income</u>
<u>1</u>	\$904 - \$1355	\$1,355.01 - \$1,805	\$1,805.01 - \$2,257
<u>2</u>	\$1,216 - \$1,822	\$1,822.01 - \$2,429	\$2,429.01 - \$3,036
<u>3</u>	\$1,527 - \$2,290	\$2,290.01 - \$3,052	\$3,052.01 - \$3,815
<u>4</u>	\$1,839 - \$2,757	\$2,757.01 - \$3,675	\$3,675.01 - \$4,594
<u>5</u>	\$2,151 - \$3,225	\$3,225.01 - \$4,299	\$4,299.01 - \$5,373
<u>6</u>	\$2,462 - \$3,692	\$3,692.01 - \$4,922	\$4,922.01 - \$6,153
<u>7</u>	\$2,774 - \$4,159	\$4,159.01 - \$5,545	\$5,545.01 - \$6,932
<u>8</u>	\$3,086 - \$4,627	\$4,627.01 - \$6,169	\$6,169.01 - \$7,711
<u>9</u>	\$3,397 - \$5,095	\$5,095.01 - \$6,792	\$6,792.01 - \$8,490
<u>10</u>	\$3,709 - \$5,562	\$5,562.01 - \$7,415	\$7,415.01 - \$9,269
<u>For more than 10 persons, add the following amounts for each additional family member.</u>			
	\$313 - \$468	\$468.01 - \$624	\$624.01 - 780

Part #5928CA1009

Section: Introduction – Summary of Major Benefits and Coverage

This chart is intended to be used to help you compare covered benefits and is a summary only. Please turn to page 14 for a detailed description of covered benefits.

NOTE: Members in the Income Category A (see the HFP Income Categories A, B, and C Table on page 1 of this notice) shall pay no more than \$5 copayments for applicable covered services, as described in the “Benefits - What is Covered Under My Child’s Plan?” section of the EOC/DF.

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
Deductibles (Money people have to pay to get a service)	There are no deductibles in the plan. You must pay a copayment for some services. This booklet has more information about copayments (see page 23). There is a maximum amount of \$250 per family in copayments for any benefit year.	n/a	n/a
Lifetime Maximums	No lifetime maximum limits on benefits apply under this plan.	n/a	n/a
Professional Services (General medical care provided by a licensed medical person)	Shots (Immunizations), periodic health exams, vision exams (with Primary Care Physician), hearing exams.	\$0	\$0
	Prenatal and postpartum care.	\$0	\$0
	Appropriate routine diagnostic testing and lab services. Physician visits in a hospital.	\$0	\$0
	Office visits, allergy tests and treatments.	\$5	\$10
Outpatient Hospital Services (Medical care services outside of the hospital)	Maternity care, diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility, use of operating room, treatment room, ancillary services, surgically implanted devices, and required drugs, radiation therapy, chemotherapy, dialysis, x-ray and laboratory services.	\$0 <u>No copayment except: \$5 per visit for emergency health care services (waived if the member is hospitalized)</u>	<u>No copayment except: \$15 per visit for emergency health care services (waived if the member is hospitalized)</u>
	Physical, occupational, and speech therapy.	\$5	\$10
Hospitalization Services	Room and board, maternity and newborn care, use of operating rooms and related ancillary charges, surgically implanted devices, medically needed drugs, x-rays and lab services, chemotherapy, and various diagnostic services.	\$0	\$0

****This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.**

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
Emergency Health Services	Emergency Room and Urgent Care Center services for an illness or injury requiring immediate diagnosis and treatment.	\$5 (Waived if hospitalized)	\$15 (Waived if hospitalized)
Well Baby Care	Office visits, health examinations, newborn hospital visits, and other office visits.	\$0	\$0
Family Planning Services	Voluntary family planning services	\$0	\$0
Ambulance Services	Use of an ambulance in an emergency situation, or when your child's PCP requests a transfer from one facility to another.	\$0	\$0
Prescription Drug Coverage (Your doctor may be able to get approval for a drug not on the Molina Healthcare "drug list")	FDA approved contraceptive drugs and devices.	\$0	\$0
	<ul style="list-style-type: none"> • FDA approved drugs prescribed by a doctor that are listed in our drug list or "drug formulary". • Drugs approved by our medical director. • For brand name or generic drugs: 30 day supply through pharmacies in network or out of network for emergent or urgent services out of the area. 90 day supply of maintenance drugs. 	\$5/prescription <ul style="list-style-type: none"> • <u>No copayment for prescription drugs provided in an inpatient setting.</u> • <u>No copayment for drugs administered in the doctor's office or in an outpatient facility.</u> 	<ul style="list-style-type: none"> • <u>\$10 copayment per prescription for up to 30 day supply for generic drugs.</u> • <u>\$15 copayment per prescription for up to 30 day supply for brand name drugs unless there is no generic equivalent or if the use of a brand name drug is medically necessary.</u> • <u>\$10 copayment per prescription for up to 90 day supply for maintenance generic drugs purchased through a participating pharmacy.</u> • <u>\$15 copayment per prescription for up to 90 day supply for maintenance brand name drugs purchased through a participating pharmacy unless there is no generic equivalent or if the use of a brand name drug is medically necessary, then the \$10</u>

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
			<u>copayment applies.</u> <ul style="list-style-type: none"> • <u>No copayment for prescription drugs provided in an inpatient setting.</u> • <u>No copayment for drugs administered in the doctor's office or in an outpatient facility.</u>
Durable Medical Equipment (Such as wheel chair, crutches etc...)	Equipment designed to serve a repeated medical purpose.	\$0	\$0
<u>Vision Services</u>	<u>Eye exams and dilated retinal exams</u>	\$0	\$0
	<u>Cataract spectacles and lenses, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery.</u>	\$0	\$0
<u>Mental Health Care Services</u>	<p>INPATIENT MENTAL HEALTH CARE SERVICES: Mental health care in a participating hospital when ordered and performed by a participating mental health professional for the treatment of a mental health condition.</p> <p>Basic Mental Health Care Services</p> <ul style="list-style-type: none"> • Diagnosis and treatment of a mental health condition. • 30 days per benefit year. Additional 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: <ul style="list-style-type: none"> ◦ 2 days of residential treatment, 	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
	<ul style="list-style-type: none"> ◦ 3 days of day care treatment, or ◦ 4 outpatient visits. <p>Severe Mental Illness (SMI)</p> <ul style="list-style-type: none"> • Inpatient mental health care services for the treatment of severe mental illnesses. • Unlimited days. <p>Serious Emotional Disturbance (SED) Services</p> <ul style="list-style-type: none"> • Inpatient mental health care services for the treatment for SED condition. • Unlimited days. <ul style="list-style-type: none"> ◦ On or before day 30; <p>Molina Healthcare may refer the member to their county mental health department for continued treatment of the SED condition. Molina Healthcare and the county mental health department will coordinate services to ensure that medically necessary services and treatment are provided to a member with a SED condition.</p> <ul style="list-style-type: none"> ◦ The member will remain <p>enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from Molina</p>	<p><u>\$0</u></p>	<p><u>\$0</u></p>

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
	Healthcare.		
	<p>OUTPATIENT MENTAL HEALTH CARE SERVICES: Mental health care when ordered and performed by a participating mental health professional.</p> <p>Basic Mental Health Care Services</p> <ul style="list-style-type: none"> • This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. • Family members may be involved in the treatment when medically necessary for the health and recovery of the child. • 20 visits per benefit year. Additional days may be authorized by Molina Healthcare. <p>Severe Mental Illness (SMI)</p> <ul style="list-style-type: none"> • Outpatient mental health care visits for the treatment of severe mental illnesses. • Unlimited visits. <p>Serious Emotional Disturbance (SED) Services</p> <ul style="list-style-type: none"> • Outpatient mental health care visits for the treatment for SED condition. • Unlimited visits. <p>◦ Molina Healthcare may refer the member to the county mental health department for treatment of SED.</p>	<p>\$5 (not applicable to SED conditions)</p> <p><u>\$5</u></p> <p><u>\$5</u></p> <p><u>\$0</u></p>	<p><u>\$10</u> (not applicable to SED conditions)</p> <p><u>\$10</u></p> <p><u>\$10</u></p> <p><u>\$0</u></p>

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
	<p>Molina Healthcare and the county mental health department will coordinate services to ensure that medically necessary services and treatment are provided to a member with a SED condition.</p> <ul style="list-style-type: none"> ◦ The member will remain enrolled in the Healthy Families Program and will continue to receive primary care, specialty care, and all other services for medical conditions not related to the SED condition from Molina Healthcare. 		
Chemical Dependency Services	Inpatient detoxification	\$0	<u>\$0</u>
	Outpatient crisis intervention and treatment, up to 20 visits per year.	\$5	<u>\$10</u>
Home Health Services	Health services provided by health care professionals. Custodial care is not covered.	\$0	<u>\$0</u>
	Physical, Occupational, and Speech therapy. See limitations.	\$5	<u>\$10</u>
Chiropractic and Acupuncture	Chiropractic and acupuncture services, maximum 20 visits per year. Referral/authorization not required.	\$5	<u>\$10</u>
Hospice Care	When elected by a terminally ill member	\$0	<u>\$0</u>
Orthotics and Prosthetics	Coverage for the initial and replacement of prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy. Also includes therapeutic footwear for diabetics and prosthetic devices to restore and achieve symmetry incident to mastectomy.	\$0	<u>\$0</u>
Skilled Nursing Care	When medically necessary. Qualified licensed skilled nursing facility. Benefit limited to 100 days per Benefit Year.	\$0	<u>\$0</u>
Blood and Blood	Include the processing, storage,	\$0	<u>\$0</u>

****This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.**

Service	Coverage	Copayment/Visit (Income Category A)	Copayment/Visit (Income Categories B & C)
Products	and administration of blood and blood products in an inpatient or outpatient setting and the collection and storage of autologous blood when Medically Necessary.		
Organ Transplants	Organ and tissue transplants are covered when medically necessary.	\$0	<u>\$0</u>
Reconstructive Surgery	Medically necessary reconstructive surgery to restore and achieve symmetry and surgery 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 or create a normal appearance, to the extent possible.	\$0	<u>\$0</u>
Diabetic Care	\$5 copayment per office visit. Copayments for prescriptions as described in the Prescription drug and medication section.	\$5	<u>\$10</u>
Cancer Clinical Trials	\$5 copayment per office visit. Copayments for prescriptions as described in the Prescription drug and medication section.	\$5	<u>\$10</u>
<u>Health Education</u>	<u>Includes education regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services.</u>	<u>\$0</u>	<u>\$0</u>

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Section: Benefits – What is Covered Under My Child’s Plan? (Benefits)

NOTE: Members in the Income Category A (see the HFP Income Categories A, B, and C Table on page 1 of this notice) shall pay no more than \$5 copayments for applicable covered services, as described in the “Benefits - What is Covered Under My Child’s Plan?” Section of the EOC/DF.

Emergency care

For each emergency room visit, your child pays \$515** (waived if hospitalized).

This means a visit to the nearest hospital or other facility that can treat your child’s emergency. If your child’s PCP directs you to another hospital or facility, it includes a visit to that hospital or facility.

Emergencies may involve, but are not limited to:

- Difficulty in breathing

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

- Seizures
- Unusual or excessive bleeding
- Unconsciousness
- Severe pain
- Possible poisoning or overdose
- Suspected broken bones
- Shock or diabetic shock

Outpatient Services

Please see copay amounts below.

Outpatient Services

- Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility (\$0)
- Physical, occupational and speech therapy as medically necessary (\$510**).
- Hospital services which can reasonably be provided on an ambulatory basis (\$0)
- Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the members stay at the facility (\$0)
- General anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary because of an underlying medical condition or clinical status or because of the severity of the dental procedure. (\$0)*
- Emergency health care services, which is waived if the member is hospitalized. (\$15**)

**This benefit is only available to members under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age. Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon are excluded for dental procedures.*

Prescription drugs and medications

Your child pays \$510** for a 30 day supply for each prescription of ~~brand name or generic~~ drugs, including tobacco cessation drugs and \$15** for a 30 day supply or each prescription of brand name drugs (unless there is not generic equivalent or if the use of a brand name drug is medically necessary). For maintenance drugs, your child must pay \$510** for a 90 day supply of generic drugs and \$15** for a 90 day supply of brand name drugs (unless there is no generic equivalent or of the use of a brand name drug is medically necessary, then the \$10** copayment applies) through Molina Healthcare participating pharmacies. Your child pays nothing for contraceptive or inpatient medications. For drugs administered in a doctor's office or outpatient clinic as part of the child's stay in a facility, your child pays nothing.

Prescription drugs and medications are covered when:

- They are prescribed by your child's doctor or another Molina Healthcare provider
- They are given while your child is in an emergency room or hospital
- They are given while your child is in a rest home, nursing home, or convalescent hospital and they are prescribed by a Plan Physician in connection with a covered service and obtained through a plan designated pharmacy.

If you need an interpreter to communicate with the pharmacy about getting your medication, call 1-888-665-4621. You may view a list of pharmacies on Molina Healthcare's website, www.molinahealthcare.com.

Physician Services

Children 2 years and younger pay nothing. Children older than 2 years, pay \$510** for each visit or home visit. No charge for preventative services. No charge for surgery, anesthesia, radiation, chemotherapy or dialysis treatments. No copay for maternity and family planning services.

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

These services are covered:

- Prevention, diagnosis, and treatment of illness or injury
- Visits to the doctor's office
- Routine pediatric and adult health exams
- Specialist consultations when referred by your child's PCP
- Injections, allergy tests and treatments when provided or referred by your child's PCP
- Physician care in or out of the hospital
- A variety of preventive care services, including health education and consultations
- Podiatry services

If your child is a female member, you may choose to see an Obstetrician/Gynecologist (OB/GYN) in your child's PCP's medical group for routine examinations and prenatal care. You do not need a referral from your child's PCP, but you may ask him or her to recommend the name(s) of an OB/GYN for your child.

Clinical Cancer Trials

Your child pays a ~~\$510**~~ office visit copayment. Please go to the "Prescription drugs and medications" section on page 17 for the copayments your child must pay for prescriptions. ~~Your child also pays \$5 for a 30-34 day supply for each prescription of brand name or generic drugs, including tobacco cessation drugs. For maintenance drugs, your child must pay \$5 for a 90-100 day supply through Molina Healthcare participating pharmacies. Your child pays nothing for inpatient medications.~~

Molina Healthcare covers routine medical costs for members participating in cancer clinical trials. Your child will never be enrolled in a clinical trial without your consent. To qualify for such coverage a Member must:

1. Be diagnosed with cancer;
2. Be accepted into an approved clinical trial for cancer;
3. Be referred by a contracted Molina Healthcare doctor and have received prior authorization from Molina Healthcare.

Treatment provided must be approved by one of the following:

1) the National Institute of Health, the federal Food and Drug Administration, the U.S. Department of defense, or the U.S. Department of Veterans Affairs, or 2) involve a drug that is exempt under the federal regulations from a new drug application.

All Referral and Authorization requirements that apply to routine care for Members not in clinical trials also apply to routine care for Members in clinical trials. Contact Molina Healthcare or your child's doctor for further information.

Home Health Care Services

Your child pays nothing. Exception: For Physical, Occupational or Speech Therapy, your child must pay ~~\$510**~~ for each visit.

These home healthcare services are covered when medically necessary and referred by your child's PCP:

- Part-time skilled nursing services
- Nurse and home health aide visits
- Physical, occupational and speech therapy
- Respiratory therapy

Home Health Services are limited to those medically necessary services that are prescribed by your child's Molina Healthcare doctor.

Physical, Occupational, and Speech Therapy

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.

Your child pays nothing for therapy performed on an inpatient basis. Your child must pay \$510** for each visit for therapy performed in the home or performed in another outpatient setting.

Physical, occupational, and speech therapy is covered when provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility, or home. Molina Healthcare may require periodic evaluations as long as therapy, which is medically necessary, is provided.

Alcohol and drug abuse

Your child pays nothing for inpatient detoxification and \$510** for outpatient services. For outpatient crisis intervention and treatment, your child must pay \$510** for each visit.

The following services are covered:

- Hospitalization for alcoholism or drug abuse as medically needed to remove toxic substances from the system
- Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically needed. Molina Healthcare offers 20 visits per benefit year.

Chiropractic and Acupuncture Services

Your child pays \$510** office visit.

- Chiropractic services are limited to treatment of the spine by means of manual manipulation.
- Acupuncture services are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent, chronic pain resulting from a generally recognized medical condition.
- These services must be provided by a Molina Healthcare Provider. You do not need an authorization or referral. You have direct access to these Providers. For more information, call our Member Services Department toll-free at 1-888-665-4621. Or, if you are deaf or hard of hearing please use our dedicated TTY number at 1-800-479-3310.
- Chiropractic and acupuncture office visits are covered for up to 20 combined visits per benefit year.

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Section: Services – Definitions

Federal Poverty Income Guideline

The federal poverty income guideline is set each year by the U.S. Department of Health and Human Services (HHS). The guidelines are used to determine eligibility for certain programs such as HFP or Medi-Cal. The poverty guidelines are sometimes referred to as the “federal poverty level” (FPL).

Income Category, A, B, or C

How much you pay for the monthly premium and copayments is determined by your income category.

The income categories are determined based on the current Federal Poverty Income Guidelines as follows:

- Income Category A = 100%-150% of the Federal Poverty Income Guideline
- Income Category B = 151%-200% of the Federal Poverty Income Guideline
- Income Category C = 201%-250% of the Federal Poverty Income Guideline

**This copayment amount is for members in Income Categories B and C (see the HFP Income Categories A, B, and C Table on page 1 of this notice). Members in Income Category A pay no more than \$5 copayments for applicable covered services.