2016
Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form

Bronze 60 HMO AI-AN

CALIFORNIA

200 Oceangate, Suite 100, Long Beach, CA 90802

[IF YOU ARE A QUALIFYING AMERICAN INDIAN OR ALASKAN NATIVE. YOU WILL HAVE NO COST SHARING IF YOU OBTAIN COVERED SERVICES FROM ANY PARTICIPATING TRIBAL HEALTH PROVIDER. HOWEVER, YOU WILL BE RESPONSIBLE FOR COST SHARING UNDER THIS PLAN FOR ANY COVERED SERVICES NOT PROVIDED BY A PARTICIPATING TRIBAL HEALTH PROVIDER. TRIBAL HEALTH PROVIDERS INCLUDE THE INDIAN HEALTH SERVICE, AN INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATION.]

MolinaHealthcare.com/Marketplace

MOLINA HEALTHCARE OF CALIFORNIA
BENEFITS AND COVERAGE GUIDE
Bronze 60 HMO AI-AN

THE GUIDE BELOW IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE MOLINA HEALTHCARE AGREEMENT AND COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS.

Except for Emergency Services and out-of-area Urgent Care Services, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to the Out-of-Pocket Maximum.

Deductible Type	At Participating Providers, You Pay
Medical Deductible	
Individual	$6000 (Deductible waived for first three primary care visits, other practitioner office visits, urgent care, and MH/SA visits)
Entire Family of 2 or more	$12,000 (Deductible waived for first three primary care visits, other practitioner office visits, urgent care, and MH/SA visits)

Deductible Type	At Participating Providers, You Pay
Other Deductibles	
Prescription Drug Deductible	
Individual	$500
Entire Family of 2 or more	$1,000
Pediatric Dental Deductible	$0

Annual Out of Pocket Maximum*	You Pay
Individual	$6,500
Entire Family of 2 or more	$13,000

*Medically Necessary Emergency Services and Urgent Care Services furnished by a Non-Participating Provider will apply to Your Annual Out of Pocket Maximum.

Emergency Room and Urgent Care Services	You Pay	
Emergency Room*	100%	Coinsurance per visit, deductible applies; waived if admitted
Emergency Physician*	100%	Coinsurance per visit, deductible applies; waived if admitted
Urgent Care	$120	Copayment per visit, deductible applies after first three non-preventive office visits

*This cost does not apply, if admitted directly to the hospital for inpatient services (Refer to Inpatient Hospital Services, for applicable Cost Sharing to You)

Outpatient Professional Services***	At Participating Providers, You Pay	
Office Visits		
Preventive Care (Includes prenatal and first postpartum exam)	No Charge (deductible waived)	
Primary Care	$70	Copayment per visit, deductible applies after first three non-preventive office visits
Other Practitioner Care	$70	Copayment per visit, deductible applies after first three non-preventive office visits
Specialty Physician Care	$90	Copayment per visit, deductible applies after first three non-preventive office visits
Habilitative Services	$70	Copayment
Rehabilitative Services	$70	Copayment
Mental/Behavioral Health Services — Office Visit — Other Items and Services	$70	Copayment per visit, deductible applies after first three non-preventive office visits
Substance Abuse Disorder Services — Office Visit — Other Items and Services	$70	Copayment per visit, deductible applies after first three non-preventive office visits
Family Planning	No Charge	

Outpatient Professional Services***	At Participating Providers, You Pay	
Pediatric Dental Services (for Members under Age 19 only) (For a complete list of Cost Shares please refer to the Pediatric Dental Addendum)		
Oral Exam, Preventive Cleaning, X-ray, Sealants, Fluoride Application Space Maintainers - Fixed	No Charge	
Amalgam Fill - 1 Surface	$25	Copayment per service, deductible applies
Root Canal - Molar	$300	Copayment per service, deductible applies
Gingivectomy per Quad	$150	Copayment per service, deductible applies
Extraction - Single Tooth Exposed Root or Erupt	$65	Copayment per service, deductible applies
Extraction - Complete Bony	$160	Copayment per service, deductible applies
Porcelain with Metal Crown	$300	Copayment per service, deductible applies
Orthodontia - Medically Necessary	$1000	Copayment per service, deductible applies
Pediatric Vision Services (for Members under Age 19 only)		
Vision Exam	No Charge	
Prescription Glasses (frames & lenses) (limited to one pair of prescription glasses once every 12 months)		
Contact Lenses (limited to once every 12 months, in lieu of prescription glasses)		

General medical care provided by a Participating Provider

Outpatient Hospital / Facility Services	At Participating Providers, You Pay	
Outpatient Surgery and Other Procedures		
Professional (Surgery and Non-Surgical Services)	100%	Coinsurance, deductible applies.
Facility(Surgery and Non-Surgical Services)	100%	Coinsurance, deductible applies.
Specialized Scanning Services (CT Scan, PET Scan, MRI)	100%	Coinsurance, deductible applies.
Radiology Services	100%	Coinsurance, deductible applies.
Laboratory Tests	100%	Coinsurance, deductible applies.
Mental Health (Outpatient Intensive Psychiatric Treatment Programs)	$70	Copayment deductible applies after first three non-preventive office visits.

Inpatient Hospital Services		At Participating Providers, You Pay
Medical / Surgical		
Professional	100%	Coinsurance, deductible applies
Facility	100%	Coinsurance, deductible applies
Maternity Care (professional and facility services)	100%	Coinsurance, deductible applies
Mental/Behavioral Health Services • Inpatient Psychiatric Hospitalization • Psychiatric Observation • Short -term in crisis residential program Hospitalization • Physician/Surgeon • Facility	100%	Coinsurance, deductible applies
Substance Abuse Disorder • Inpatient Detoxification • Inpatient Services • Transitional Residential Recovery Services • Recovery Services • Physician/Surgeon • Facility	100%	Coinsurance, deductible applies
Skilled Nursing Facility (limited to 100 days per benefit period)	100%	Coinsurance, deductible applies
Hospice Care	No Charge	

Prescription Drug Coverage	At Participating Providers, You Pay	
Tier 1	100%	Coinsurance, up to $500 maximum per script after pharmacy deductible applies
Tier 2	100%	Coinsurance, up to $500 maximum per script after pharmacy deductible applies
Tier 3	100%	Coinsurance, up to $500 maximum per script after pharmacy deductible applies
Tier 4	100%	Coinsurance, up to $500 maximum per script after pharmacy deductible applies (Maximum Cost Sharing of $200 for a 30-day supply of oral chemotherapy drugs)
Mail-order Prescription Drugs	A 90-day supply is offered at two times the one-month retail prescription benefit cost share.	

Please refer to the Prescription Drug Coverage **section for a description of prescription drug coverage.**

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	100%	Coinsurance, deductible applies
Home Healthcare (limited to 100 days per benefit period)	100%	Coinsurance, deductible applies
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for Participating and Non-Participating Providers.)	100%	Coinsurance, deductible applies
Non-Emergency Medical Transportation (Ambulance)	100%	Coinsurance, deductible applies

Other Services	At Participating Providers, You Pay	
Dialysis Services	$70	Copayment, deductible applies

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This Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form (also called the "**EOC**" or "**Agreement**") is issued by Molina Healthcare of California ("**Molina Healthcare**", "**Molina**", "**We**", or "**Our**"), to the Subscriber or Member whose identification cards are issued with this Agreement. In consideration of statements made in any required application and timely payment of Premiums, Molina Healthcare agrees to provide the Benefits and Coverage as described in this Agreement.

This Agreement, amendments to this Agreement, and any application(s) submitted to Molina Healthcare and or Covered California to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the legally binding contract between Molina Healthcare and the Subscriber.

WELCOME

Welcome to Molina Healthcare!

Here at Molina, We will help You meet Your medical needs. **Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form**. This document will be printed in English, Spanish, Arabic, Cantonese, Hmong, Russian and Vietnamese.

Please contact the Customer Support Center toll-free at **1 (888)** 858**-**2150**,** Monday through Friday, 8:00am to 6:00pm, for information when necessary.

If You are a Molina Healthcare Member, this EOC tells You what services You can get. If You are thinking about becoming a Molina Healthcare Member, this EOC can help You make a decision. You may call Molina Healthcare and request Your own copy.

Molina Healthcare is a California Knox-Keene Licensed Health Plan.

We can help You understand this Agreement. If You have any questions about anything in this Agreement, call Us. You can call if You want to know more about Molina. You can get this information in another language, large print, Braille, or audio. You may call or write to Us at:

Molina Healthcare of California
Customer Support Center
200 Oceangate, Suite 100
Long Beach, CA 90802
1 (888) 858-2150
www.molinahealthcare.com
If You are deaf or hard of hearing You may contact Us through Our dedicated TTY line.
You may also dial 711 for the Telecommunications Service.

INTRODUCTION

Thank You for choosing Molina Healthcare as Your health plan.
This document is called Your "Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form" (Your "Agreement" or "EOC"). The EOC tells You how You can get services through Molina Healthcare. It also sets out the terms and conditions of coverage under this Agreement. . It tells You Your rights and responsibilities as a Molina Member. It explains how to contact Molina. Please read this EOC completely and carefully. Keep it in a safe place where You can get to it quickly. There are sections for special health care needs.

Molina is here to serve You.

Call Molina if You have questions or concerns. Our helpful and friendly staff will be happy to help You. We can help You:

- Arrange for an interpreter
- Check on Prior Authorization Status
- Choose a Primary Care Provider
- Make an appointment
- Make a Payment

We can also listen and respond to any of Your questions or complaints about Your Molina product.

Call us toll-free at 1 (888) 858-2150 between 8:00 a.m. to 6:00 p.m. Monday through Friday. If You are deaf or hard of hearing, You may contact us You can also dial 711 for the Telecommunications Service.

Call Us if You move from the address You had when You enrolled with Molina or if You change phone numbers.

YOUR PRIVACY

Your privacy is important to us. We respect and protect Your privacy. Molina Healthcare uses and shares Your information to provide You with health benefits. Molina Healthcare wants to let You know how Your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Our Members' PHI?

- To provide for Your treatment
- To pay for Your health care
- To review the quality of the care You get
- To tell You about Your choices for care
- To run Our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?
Molina Healthcare needs Your written approval to use or share Your PHI for purposes not listed above.

What are Your privacy rights?

- To look at Your PHI
- To get a copy of Your PHI
- To amend Your PHI
- To ask us to not use or share Your PHI in certain ways
- To get a list of certain people or places We have given Your PHI

How does Molina Healthcare protect Your PHI?
Molina Healthcare uses many ways to protect PHI across Our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina Healthcare protects PHI:

- Molina Healthcare has policies and rules to protect PHI.
- Molina Healthcare limits who may see PHI. Only Molina Healthcare staff with a need to know PHI may use it.
- Molina Healthcare staff is trained on how to protect and secure PHI.
- Molina Healthcare staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina Healthcare secures PHI in Our computers. PHI in Our computers is kept private by using firewalls and passwords.

The above is only a summary. Our Notice of Privacy Practices has more information about how We use and share Our Members' PHI. Our Notice of Privacy Practices is in the following section of this EOC and is on Our web site at www.molinahealthcare.com**. You may also get a copy of Our Notice of Privacy Practices by calling Our Customer Support Center at 1-888-**858-2150**.**

NOTICE OF PRIVACY PRACTICES
MOLINA HEALTHCARE OF CALIFORNIA

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of California ("**Molina Healthcare**", "**Molina**", "**We**", or "**Our**") uses and shares protected health information about You to provide Your health benefits. We use and share Your information to carry out treatment, payment and health care operations. We also use and share Your information for other reasons as allowed and required by law. We have the duty to keep Your health information private and to follow the terms of this notice. The effective date of this notice is January 1, 2015.

PHI stands for these words, protected health information. PHI means health information that includes Your name, Member number or other identifiers, and is used or shared by Molina Healthcare.

Why does Molina Healthcare use or share Your PHI?
We use or share Your PHI to provide You with healthcare benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment
Molina Healthcare may use or share Your PHI to give You, or arrange for, Your medical care. This treatment also includes referrals between Your doctors or other health care providers. For example, We may share information about Your health condition with a Specialist Physician. This helps the Specialist Physician talk about Your treatment with Your doctor.

For Payment
Molina Healthcare may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, Your condition, Your treatment, and supplies given may be written on the bill. For example, We may let a doctor know that You have Our benefits. We would also tell the doctor the amount of the bill that We would pay.

For Health Care Operations
Molina Healthcare may use or share PHI about You to run Our health plan. For example, We may use information from Your claim to let You know about a health program that could help You. We may also use or share Your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address Member needs, including solving complaints and grievances.

We will share Your PHI with other companies ("**business associates**") that perform different kinds of activities for Our health plan. We may also use Your PHI to give You reminders about

Your appointments. We may use Your PHI to give You information about other treatment, or other health-related benefits and services.

When can Molina Healthcare use or share Your PHI without getting written authorization (approval) from You?

The law allows or requires Molina Healthcare to use and share Your PHI for several other purposes including the following:

Required by law

We will use or share information about You as required by law. We will share Your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need Your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness, or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect, or Domestic Violence

Your PHI may be shared with legal authorities if We believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures

Your PHI may be shared with funeral directors or coroners to help them to do their jobs.

When does Molina Healthcare need Your written authorization (approval) to use or share Your PHI?

Molina Healthcare needs Your written approval to use or share Your PHI for a purpose other than those listed in this notice. Molina needs Your authorization before We disclose Your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that You have given us. Your cancellation will not apply to actions already taken by us because of the approval You already gave to us.

What are Your health information rights?
You have the right to:

- **Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)**
  You may ask us not to share Your PHI to carry out treatment, payment, or health care operations. You may also ask us not to share Your PHI with family, friends, or other persons You name who are involved in Your health care. However, We are not required to agree to Your request. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Request Confidential Communications of PHI**
  You may ask Molina Healthcare to give You Your PHI in a certain way or at a certain place to help keep Your PHI private. We will follow reasonable requests, if You tell us how sharing all or a part of that PHI could put Your life at risk. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

- **Review and Copy Your PHI**
  You have a right to review and get a copy of Your PHI held by us. This may include records used in making coverage, claims, and other decisions as a Molina Healthcare Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. We may charge You a reasonable fee for copying and mailing the records. In certain cases We may deny the request. *Important Note: We do not have complete copies of Your medical records. If You want to look at, get a copy of, or change Your medical records, please contact Your doctor or clinic.*

- **Amend Your PHI**
  You may ask that We amend (change) Your PHI. This involves only those records kept by us about You as a Member. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request. You may file a letter disagreeing with us if We deny the request.

- **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**
  You may ask that We give You a list of certain parties that We shared Your PHI with during the six years prior to the date of Your request. The list will not include PHI shared as follows:
    - for treatment, payment or health care operations;
    - to persons about their own PHI;
    - sharing done with Your authorization;
    - incident to a use or disclosure otherwise permitted or required under applicable law;
    - as part of a limited data set in accordance with applicable law.

  We will charge a reasonable fee for each list if You ask for this list more than once in a 12-month period. You will need to make Your request in writing. You may use Molina Healthcare's form to make Your request.

  You may make any of the requests listed above, or may get a paper copy of this Notice. Please call Our Customer Support Center at 1-888-858-2150.

What can You do if Your rights have not been protected?
You may complain to Molina Healthcare and to the Department of Health and Human Services if You believe Your privacy rights have been violated. We will not do anything against You for filing a complaint. Your care and benefits will not change in any way.

You may complain to us at:

Customer Support Center
200 Oceangate, Suite 100
Long Beach, CA 90802
1-888-858-2150

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
50 United Nations Plaza - Room 322
San Francisco, CA 94102
1-415-437-8310; 1-415-437-8311 (TDD)
1-415-437-8329 FAX

What are the duties of Molina Healthcare?
Molina Healthcare is required to:
- Keep Your PHI private;
- Give You written information such as this on Our duties and privacy practices about Your PHI;
- Provide You with a notice in the event of any breach of Your unsecured PHI;
- Not use or disclose Your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina Healthcare reserves the right to change its information practices and terms of this notice at any time. If We do, the new terms and practices will then apply to all PHI We keep. If We make any material changes, Molina will post the revised Notice on Our website and send the revised Notice or information about the material change and how to obtain the revised Notice, in Our next annual mailing to Our Members then covered by Molina.

Contact Information

If You have any questions, please contact the following office:

Customer Support Center
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: 1-888-858-2150

HELP FOR NON-ENGLISH SPEAKING MOLINA HEALTHCARE MEMBERS

As a Molina Healthcare Member, You have access to interpreter services on a twenty four (24) hour basis. You do not need to have a minor, friend, or family member act as Your interpreter. You may wish to say things that You do not wish to share with a minor, friend or family member. Using an interpreter may be better for You.

If Molina Healthcare has wrong information about Your language needs, please call the Customer Support Center toll-free at 1(888) 858-2150.

Call us if You have any questions.
Customer Support Center toll-free at: 1 (888) 858-2150

If You are deaf or hard of hearing You may contact us by dialing 711 for the California Relay Service.

If You need help understanding the enclosed information in Your language, please call the Molina Healthcare Customer Support at 1 (888) 858-2150

DEFINITIONS

Some of the words used in this EOC do not have their usual meaning. Health plans use these words in a special way. When We use a word with a special meaning in only one section of this EOC, We explain what it means in that section. Words with special meaning used in any section of this EOC are explained in this "Definitions" section.

"**Affordable Care Act**" means the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, together with the federal regulations implementing this law and binding regulatory guidance issued by federal regulators.

"**Annual Out-of-Pocket Maximum**"
For Individuals - is the maximum amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of California, Inc. Benefits and Coverage Guide. For this EOC, Cost Sharing includes payments You make towards any Deductibles, Copayments, or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Your Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the individual Annual Out-of-Pocket Maximum. Please refer to page 110 for information on how Your Pediatric Dental Essential Health Benefits Annual Out-of-Pocket Maximum applies.

For Family (2 or more Members) – is the maximum amount of Cost Sharing that a Family of at least two or more Members will have to pay for Covered Services in a calendar year. An individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your Agreement are specified in the Molina Healthcare of California, Inc. Benefits and Coverage Guide. For this Agreement, Cost Sharing includes payments You or other family members enrolled as Members under this EOC make towards any Deductibles, Copayments, or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, We will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this EOC will not count towards the family Annual Out-of-Pocket Maximum. Please refer to page 110 for information on how Your Pediatric Dental Essential Health Benefits Annual Out-of-Pocket Maximum applies.

"**Authorization or Authorized**" (also "Prior Authorization" or "Approval) means a decision to approve specialty or other Medically Necessary care for a Member by the Member's PCP or medical group.
"**Benefits and Coverage**" (also referred to as "Covered Services") means the healthcare services that You are entitled to receive from Molina under this Agreement.

"Child-Only Coverage" means coverage under this Policy that is obtained by a responsible adult to provide benefit coverage only to a child under the age of 21.

"**Coinsurance**" is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina Healthcare has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of California Benefits and Coverage Guide. Some Covered Services do not have Coinsurance, and may apply a Deductible or Copayment.

"**Copayment**" is a specific dollar amount You must pay when You receive Covered Services.

Copayments are listed in the Molina Healthcare of California Benefits and Coverage Guide. Some Covered Services do not have a Copayment, and may apply a Deductible or Coinsurance.

"**Cost Sharing**" is the Deductible, Copayment, and/or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of California Benefits and Coverage Guide at the beginning of this EOC.

"**Covered California**" is an independent public program to help Californians buy health care coverage from insurance companies and health plans such as Molina Healthcare.

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of California Benefits and Coverage Guide at the beginning of this EOC

Please refer to the Molina Healthcare of California Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. However for preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.

There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

when You meet the Deductible for the individual Member; or
when Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible

"**Dependent**" means a Member who meets the eligibility requirements as a Dependent, as described in this EOC.

"**Drug Formulary**" is Molina Healthcare's list of approved drugs that doctors can order for You.

"**Durable Medical Equipment**" is medical equipment that serves a repeated medical purpose and is intended for repeated use. It is generally not useful to You in the absence of illness or injury and does not include accessories primarily for Your comfort or convenience. Examples include, without limitation: oxygen equipment, blood glucose monitors, apnea monitors, nebulizer machines, insulin pumps, wheelchairs, and crutches.

"**Emergency**" or "**Emergency Medical Condition"** means the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity. Including severe pain, which the absence of immediate medical attention could reasonably be expected by a reasonable layperson, to result in:

- Placing the health of the Member in serious jeopardy
- Serious impairment of bodily functions,
- Serious dysfunction of any bodily organ or part, or
- Disfigurement to the person.

Emergency Medical Condition will also include additional screening, examination and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if a Psychiatric Emergency Medical Condition exists. Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

"**Emergency Services**" or "**Emergency Services and Care**" medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency Services" or "Emergency Services and Care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital or an acute psychiatric hospital, as defined by state law.

"**Essential Health Benefits**" or "**EHB**" means a standardized set of essential health benefits that are required to be offered by Molina Healthcare to You and/or Your Dependents, as determined by the Affordable Care Act. Essential Health Benefits covers at least the following 10 categories of benefits:

- Ambulatory patient care
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services. This includes behavioral health treatment
- Prescription drugs
- Rehabilitative and Habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including dental* and vision care for Members under the age of 19

"**Experimental or Investigational**" means any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

"**Medically Necessary"** or "**Medical Necessity**" means health care services that a physician, dentist/orthodontist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. Those services must be deemed by Molina to be:

- In accordance with generally accepted standards of medical or dental/orthodontic practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or dental/orthodontic or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice or dental/orthodontic" means standards that are based on credible scientific evidence published in peer-reviewed medical or dental literature generally recognized by the relevant medical or dental community, physician specialty society recommendations, the views of physicians or dental/orthodontists practicing in relevant clinical areas and any other relevant factors.
"**Molina Healthcare of California** ("**Molina Healthcare**" or "**Molina**")" means the corporation licensed to provide prepaid medical and hospital services under the Knox-Keene Health Care Service Plan Act of 1975, and contracted with Covered California. This EOC sometimes refers to Molina Healthcare of California as "We" or "Our".

"**Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form**" means this booklet, which has information about Your benefits. It is also called the "EOC" or "Agreement".

"**Member**" (also "You" or "Your") means an individual who is eligible and enrolled under this Agreement, and for whom We have received applicable Premiums. The term includes a Dependent and a Subscriber, unless the Subscriber is a responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21. In which case, the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Product but will not be a Member.

"**Non-Participating Provider"** refers to those physicians, hospitals, and other providers that have not entered into contracts to provide Covered Services to Members.

"**Obstetrician-gynecologist**" (also "**OB/GYN**") means a physician who is board eligible or board certified by the American board of obstetricians and gynecologists or by the American college of osteopathic obstetricians and gynecologists.

"**Other Practitioner**" refers to Participating Providers who provide Covered Services to Members within the scope of their license, but are not Primary Care Physicians or Specialist Physicians.

"**Participating Provider**" refers to those providers, including hospitals and physicians that are contracted with Molina Healthcare to provide Covered Services to Members through this product offered and sold through Covered California.

"**Premiums**" mean periodic membership charges paid by or on behalf of each Member. Premiums are in addition to Cost Sharing.

"**Primary Care Doctor**" (also a "**Primary Care Physician**" and "**Personal Doctor**") is the doctor who takes care of Your health care needs. Your Primary Care Doctor has Your medical history. Your Primary Care Doctor makes sure You get needed health care services. A Primary Care Doctor may refer You to specialist physicians or for other services. A Primary Care Doctor may be one of the following types of doctors:

- Family or general practice doctor who usually can see the whole family.
- Internal medicine doctor, who usually only see adults and children 14 years or older.
- Pediatrician, who see children from newborn to age 18 or 21.
- Obstetricians and gynecologists (OB/GYNs).

"**Primary Care Provider**" or "**PCP**" means 1) a Primary Care Doctor, 2) an individual practice association (IPA) or group of licensed doctors which provides primary care services through the Primary Care Doctor

"**Referral**" means the process by which the Member's Primary Care Doctor directs him/her to seek and obtain Covered Services from other providers.

"**Service Area**" means the geographic area in California where Molina Healthcare has been authorized by the California Department of Managed Health Care to market individual products sold through Covered California, enroll Members obtaining coverage through Covered California and provide benefits through approved individual health products sold through Covered California.

"**Specialist Physician**" means any licensed, board-certified, or board-eligible physician who practices a specialty and who has entered into a contract to deliver Covered Services to Members.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this EOC, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code, or the Subscriber's registered domestic partner who meets all the requirements of Sections 297 or 299.2 of the California Family Code.

"**Subscriber**" means either:

- An individual who is a resident of California, satisfies the eligibility requirements of this Agreement, is enrolled and accepted by Molina as the Subscriber, and has maintained membership with Molina in accord with the terms of this Agreement; or
- A responsible adult (the parent or legal guardian) who applies for Child-Only Coverage under this Agreement on behalf of a child under age 21, in which case the Subscriber will be responsible for making the Premium and Cost Sharing payments for the Member, and will act as the legal representative of Member under this Agreement.

"**Urgent Care Services"** mean medically necessary health care services provided in an Emergency or after a primary care physician's normal business hours for unforeseen medical conditions due to illness or injury, including pregnancy. that are not life threatening but require prompt medical attention.

ELIGIBILITY AND ENROLLMENT

When Will My Molina Membership Begin?
Your coverage begins on the Effective Date. The Effective Date is the date You meet all enrollment and Premium pre-payment requirements. It is the date You are accepted by Molina Healthcare and or Covered California.

For coverage during the calendar year 2016, the initial open enrollment period begins November 1, 2015 and ends January 31, 2015. Your Effective Date for coverage during 2016 will depend on when You applied:

If You applied on or before November 1, 2015, the Effective Date of Your coverage is January 1, 2016. If You applied between December 16, 2015 and January 15, 2016, the Effective Date of Your coverage is February 1, 2016. If You applied from January 16, 2016 through January 31, 2016, the Effective Date of Your coverage is March 1, 2016.

If You do not enroll during an open enrollment period, You may be able to enroll during a special enrollment period. You must be eligible under the special enrollment procedures established by Covered California. In such case, the Effective Date of coverage will be determined by Covered California and or Molina Healthcare. Without limiting the above, Covered California and Molina will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

Effective Date for coverage of new Dependents is described below in the section titled "Adding New Dependents".

Who is Eligible?
To enroll and stay enrolled You must meet all of the eligibility requirements established by Covered California and Molina Healthcare. Covered California's eligibility criteria can be found at www.coveredca.com. Molina requires You to live or reside in Our Service Area for this product. For Child-Only Coverage, the Member must be under the age of 21, and the Subscriber must be a responsible adult (parent or legal guardian) applying on behalf of the child. Molina requires Members to live or reside in Molina's Service Area for this Policy. If You have lost Your eligibility, You may not be able to re-enroll. This is described in the section titled "When Will My Molina Membership End? (Termination of Benefits and Coverage)."

Dependents
Subscribers who enroll in this product during the open enrollment period established by Covered California may also apply to enroll eligible Dependents who satisfy the eligibility requirements. Molina Healthcare requires Dependents to live or reside in Molina Healthcare's Service Area for this product. The following types of family members are considered Dependents:

- Spouse
- Children: The Subscriber's children or his or her Spouse's children (including legally adopted children and stepchildren). Each child is eligible to apply for enrollment as a Dependent until the age of 26 (the limiting age).
- Subscriber's grandchildren generally do not qualify as Dependents of the Subscriber unless added as a newborn child of a covered Dependent child or of a Member covered by Child-Only Coverage under this Agreement. Coverage for children of a covered Dependent child or of a Member under a Child-Only Coverage will end when the covered Dependent child or Member under a Child-Only Coverage is no longer eligible under this Agreement.

Age Limit for Disabled or Handicapped Children: Children who reach age 26 are eligible to continue enrollment as a Dependent for coverage if each of the following conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition
 The child is chiefly dependent upon the Subscriber for support and maintenance.

Molina will provide the Subscriber with notice at least ninety (90) calendar days prior to the date the Subscriber's enrolled child reaches the limiting age. At this time, the Dependent child's coverage will end. The Subscriber must give Molina proof of his or her child's incapacity and dependency. This must happen within sixty (60) calendar days of the date of receiving such notice from Molina. This must occur in order to continue coverage for a disabled child past the limiting age.

The Subscriber must provide the proof of incapacity and dependency at no cost to Molina Healthcare. Molina Healthcare may require annual proof of continued incapacity and dependency, following the two-year period after the child's attainment of age 26.

A disabled child may remain covered by Molina as a Dependent. This applies as long as he or she remains incapacitated. The child must initially meet and continue to meet the above-described eligibility criteria described.

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after You as the Subscriber are enrolled (such as a new Spouse, a newborn child, newly adopted child, Foster Child, or a child only dependent), You must contact Molina HealthcareorCovered California and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to Molina Healthcare and or Covered California within sixty (60) calendar days from the date the Dependent became eligible to enroll with Molina Healthcare.

Spouse: You can add a Spouse as long as You apply during the open enrollment period.

You can also apply no later than 60 days after any event listed below:

- The Spouse loses "minimum essential coverage" through:
- Government sponsored programs,
- Employer-sponsored plans,
- Individual market plans, or
- Any other coverage designated as "minimum essential coverage" in compliance with the Affordable Care Act.
- The date of Your marriage or the date the Declaration of Domestic Partnership is filed with the California Secretary of State;
- The Spouse, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The Spouse permanently moves into the service area.

Children Under 26 Years of Age: You can add a Dependent under the age of 26, including a stepchild, as long as You apply during the open enrollment period or during a period no longer than sixty (60) calendar days after any event listed below:

- The child loses "minimum essential coverage" through Government sponsored programs, Employer-sponsored plans, Individual market plans, or any other coverage designated as "minimum essential coverage" as determined by the Affordable Care Act.
- The child becomes a Dependent through marriage, Domestic Partnership registration, birth, placement in foster care, adoption, placement for adoption, child support, or other court order.
- The child, who was not previously a citizen, national, or lawfully present individual, gains such status.
- The child permanently moves into the service area.

Newborn Child: Coverage for a newborn child is from the moment of birth. However, if You do not enroll the newborn child within sixty (60) calendar days, the newborn is covered for only thirty-one (31) calendar days (including the date of birth).

Adopted Child: A newly adopted child or child placed with You or Your Spouse for adoption is covered from whichever date is earlier:

- The date of adoption or placement for adoption.
- The date You or Your Spouse gain the legal right to control the child's health care.

If You do not enroll the adopted child or child placed with You or Your Spouse within 60 days, the child is covered for only 31 days. This includes the date of adoption placement for adoption or when the legal right to control the child's health care was gained, whichever is earlier. For purpose of this requirement, "legal right to control health care" means You or Your Spouse have:

- A signed written document. This can be:
- a health facility minor release report
- a medical authorization form, or
- a relinquishment form) or
- Other evidence that shows You or Your Spouse has the legal right to control the child's health care.

Foster Child: If a child is placed with You or Your spouse for foster care, then the child shall be eligible for coverage under this Agreement. A foster child can be added to this Agreement during the open enrollment period or within 60 days of the child's placement with You in foster care. The child's coverage shall be effective on the date of placement in foster care or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

Discontinuation of Dependent Benefits and Coverage: Benefits and Coverage for Your Dependent will be discontinued:

- When the dependent child attains age 26, unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children Age Limit for Disabled or Handicapped Children".
- The date the Dependent Spouse enters a final decree of divorce, annulment, dissolution of marriage from the Subscriber.
- The date the Dependent Domestic Partner enters a termination of the domestic partnership from the Subscriber.

Continued Eligibility: A Member is no longer eligible for this product if:

- The Member becomes abusive or violent and threatens the safety of anyone who works with Molina Healthcare, including Participating Providers.
- The Member substantially impairs the ability of Molina Healthcare, or anyone working with Molina Healthcare, including Participating Providers, to provide care to the Member or other Members.
- There is a breakdown in the Member's relationship with the Member's doctor and Molina does not have another doctor for the Member to see. This may not apply to Members refusing medical care.

If You are no longer eligible for this product, We will send You a letter letting You know at least ten (10) calendar days before the effective date on which You will lose eligibility. At that time, You can appeal the decision.

MEMBER IDENTIFICATION CARD

How do I Know if I am a Molina Healthcare Member?
You get a Member identification card (ID card) from Molina Healthcare. Your ID card comes in the mail within 10 business days after You make your first payment. Your ID card lists Your Primary Care Doctor's name and phone number. Carry Your ID card with You at all times. You must show Your ID card every time You get health care. If You lose Your ID card, call Molina Healthcare toll-free at 1 (888) 858-2150. We will be happy to send You a new ID card.

If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-2150.

Sample ID card

Molina Marketplace
ID #: 00000001
Member: THIS IS A REALLY LONG NAME OF A MEMBER 1
DOB: 11/13/1964
Plan: Marketplace 2015 CA
Subscriber Name:
Subscriber ID: 123456789
Provider: This is a really, really, really, really long PCP name to test for wrapping of the
Provider Phone: (001) 001-0001
Provider Group: UNIVERSITY DEPARTMENT OF FAMILY AND PREVENTATIVE MEDICI

Medical Cost Share
Primary Care: $1
Specialist Visits: $7
Urgent Care: $5
ER Visit: $8

Prescription Drugs
Generic Drugs: $5
Preferred Brand Drugs: $2
Non-Preferred Brand Drugs: $3
Specialty Drugs: $40

Molina Healthcare of California, Inc. Rx Bin: 004336 Rx PCN: ADV Rx Group: RX0845

This card is for identification purposes only and does not prove eligibility for service.
Member: Emergencies (24 hrs): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
Miembro: Emergencias (24 horas): cuando una emergencia puede resultar en muerte o disabilidad, llame al 911 imediatamente o vaya a la sala de emergencia mas cercana. No requiere autorización para servicios de emregencia.
Remit claims to: Molina Healthcare, P.O. Box 22702, Long Beach, CA 90801
Medical Customer Support Number: (888) 858-2150
24 Hour Nurse Advice Line: (888) 275-8750
Pediatric Dental Customer Support Number: (855) 230-5530
Para Enfermera En Español: (866) 648-3537
CVS Caremark Pharmacy Help Desk: (800) 364-6331
Provider: Notify the health plan within 24 hours of any inpatient admission at the hospital admission notification phone number.
Prior Authorization/Notification of Hospital Admission and Covered Services: (855) 322-4075
www.MolinaHealthcare.com

What Do I Do First?
Look at Your Molina Healthcare Member ID card. Check that Your name and date of birth are correct. Your ID card will tell You the name of Your doctor. This person is called Your Primary Care Provider or PCP. This is Your main doctor. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- Your Primary Care Provider's name (Provider)
- Your Primary Care Provider's office phone number (Provider Phone)
- The name of the medical group Your PCP is associated with (Provider Group)
- Molina Healthcare's 24 hours Nurse Advice Line toll-free number 1 (888) 275-8750.
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- Toll free number for prescription related questions: CVS Caremark Pharmacy Help Desk 1 (800) 364-6331
- Toll free number for hospitals to notify Molina Healthcare of admissions for Our Members
- Toll free number for emergency rooms to notify Molina Healthcare of emergency room admissions for Our Members Emergencies (24 hrs.): when a medical emergency might lead to disability or death, call 911 immediately or get to the nearest emergency room. No prior authorization is required for emergency care.
- If You have questions about how health care services may be obtained, You can call Molina Healthcare's Customer Support Center toll-free at 1-888-858-2150.

Your ID card is used by health care providers such as Your Primary Care Doctor, pharmacist, hospital and other health care providers to determine Your eligibility for services through Molina Healthcare. When accessing care You may be asked to present Your ID card before services are provided.

ACCESSING CARE

How Do I Get Medical Services Through Molina Healthcare?
(Choice of Doctors and Providers; Facilities)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHO OR WHAT GROUP OF PROVIDERS' HEALTH CARE SERVICES MAY BE OBTAINED.

Your Provider Directory includes a list of the Primary Care Providers and hospitals that are available to You as a Member of Molina Healthcare. You may visit Molina's website at www.molinahealthcare.com/**marketplace** to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

The first person You should call for any health care is Your Primary Care Provider.

If You need hospital or similar services, You must go to a Health Care Facility that is a Participating Provider. For more information about which facilities are with Molina or where they are located, call Molina toll-free at 1-888-858-2150. You may get Emergency Services or out of area Urgent Care Services in any emergency room or urgent care center.

Except for Emergency Services, out-of-area urgent Care Services and Medically Necessary Prior Authorized Services you must receive Covered Services from participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment and the payments will not apply to the Out-of-Pocket Maximum.

This chart is to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. The right side tells You who to call or where to go.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHOM TO CALL.
Emergency Services	Call 911 or go to the nearest emergency room. Even when You are outside of Molina Healthcare's network or Service Area, please call 911 or go to the nearest emergency room for Emergency care.
Urgent Care Services	Call Your PCP or Molina Healthcare's 24-Hour Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537 for directions. For out of area Urgent Care Services You may also go to the nearest urgent care center or emergency room.
A physical exam, wellness visit or immunizations	Go to Your PCP
Treatment for an illness or injury that is not an Emergency	Go to Your PCP
Family planning services, such as: • Pregnancy tests • Birth control • Sterilization	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
Tests and treatment for Sexually Transmitted Diseases (STDs)	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.
To see an OB/GYN (woman's doctor).	Women may go to any Participating Provider

TYPE OF HELP YOU NEED:	WHERE TO GO. WHOM TO CALL.
	OB/GYN without a Referral or Prior Authorization. Ask Your doctor or call Molina Healthcare's Customer Support Center if You do not know an OB/GYN.
For mental health or substance abuse evaluation	Go to a qualified mental health Participating Provider. You do not need a Referral or Prior Authorization to get a mental health or substance abuse evaluation.
For mental health or substance abuse therapy	For mental health or substance abuse therapy, see a qualified mental health provider.
To see a Specialist Physician (for example, cancer or heart doctor)	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
To have surgery	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services and out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
To get a second opinion	Consult Your Provider Directory on Our website at www.molinahealthcare.com to find a Participating Provider for a second opinion.
To go to the Hospital	Go to Your PCP first. Your doctor will give You a Referral if needed. If You need Emergency Services or out-of-area Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
After-hours care	Call Your PCP for a Referral to an after-hours clinic or other appropriate care center. You can also call Molina Healthcare's Nurse Advice Line toll-free at 1 (888) 275-8750 or, for Spanish, at 1 (866)648-3537. You also have the right to interpreter services at no cost to You to help in getting after hours care. Call toll-free 1 (888) 858-2150.

What is a Primary Care Provider?
A **PRIMARY CARE** Provider (**OR PCP**) takes care of Your health care needs. A PCP knows You well. Call Your PCP when You are sick and You do not know what to do. You do not have to go to the emergency room unless You believe You have an Emergency Condition.

You may think that You should not see Your PCP until You are sick. That is not true.

Get to know Your PCP even when You are well. Go for yearly check-ups to stay healthy. Go to Your PCP for check-ups, tests and test results, shots, and when You are ill. Seeing Your PCP for check-ups allows problems to be found early. If You need special care, Your PCP will help You get it. Your PCP and You work together to keep You healthy.

If You want to know more about Your PCP or other Molina Healthcare doctors, call Us. Molina's Customer Support Center number is toll-free at 1 (888) 858-2150. We can give You information about Your doctor's qualifications, such as:

- Medical school attended
- Residency completed
- Board certification status
- Languages Your doctor speaks.

Choosing Your Doctor (Choice of Physician and Providers)
For Your health care to be covered under this product, Your health care services must be provided by Molina Healthcare Participating Providers (doctors, hospitals, Specialist Physicians or medical clinics), except in the case of Emergency Services or out of area Urgent Care Services. Please see "Emergency Services and out of area Urgent Care Services" for more information.

Our Provider Directory will help You get started in making decisions about Your health care. You will find a listing of doctors and hospitals that are available under Molina's health plan. You will also learn some helpful tips on how to use Molina services and benefits. Visit Molina's website at www.molinahealthcare.com/marketplace and click Find a Doctor or Pharmacy for more information or You can call Molina Healthcare toll-free at 1 (888) 858-2150.

You can find the following in Molina's Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Professional qualifications (e.g. board certification)
- You can also find out if a Participating Provider is taking new patients. This includes doctors, Specialists Physicians, hospitals, or medical clinics.

How Do I Choose a Primary Care Provider (PCP)?
It is easy to choose a Primary Care Provider (or PCP). Use Our Provider Directory to select from a list of doctors. You may want to choose one doctor who will see Your whole family. Alternatively, You may want to choose one doctor for You and another one for Your family members.

Your PCP knows You well and takes care of all Your medical needs. Choose a PCP as soon as You can. It is important that You feel comfortable with the PCP You choose.

Call and schedule Your first visit to get to know Your PCP. If You need help making an appointment, call Molina Healthcare toll-free at 1 (888) 858-2150. Molina Healthcare can also help You find a PCP. Tell Us what is important to You in choosing a PCP. We are happy to help You. Call the Customer Support Center if You want more information about Your doctor.

What if I Don't Choose a Primary Care Provider?
Molina asks that You select a Primary Care Provider within 30 days of joining Molina. However, if You do not choose a PCP, we will choose one for You.

CHANGING YOUR DOCTOR

What if I Want to Change my Primary Care Provider?
You can change Your PCP at any time. All changes made by the 25th of the month will be in effect on the first day of the next calendar month. All changes made on or after the 26th of the month, the effective date will be the first day of the second calendar month. First visit Your doctor. Get to know Your PCP before changing. A good relationship with Your PCP is important to Your health care. Call the Customer Support Center if You want more information about Your Molina doctor.

Can my Primary Care Provider request that I change to a different Primary Care Provider?
Your Primary Care Provider may request that You be changed to a different PCP for any of the following reasons:

- You are not following medical instructions (non-compliant behavior)
- You are being abusive, threatening or have violent behavior
- Doctor-patient relationship breakdown

How do I Change my Primary Care Provider?
Call Molina Healthcare toll-free at 1 (888) 858-2150, Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also visit Molina's website at www.molinahealthcare.com/marketplace to view Our online list of doctors. Let Us help You make the change.

- Sometimes You may not be able to get the PCP You want. This may happen because:
- The PCP is no longer a Participating Provider with Molina Healthcare.
- The PCP already has all the patients he or she can take care of right now.

What **if my doctor** or **hospital is not with** Molina?
existing Members, if Your doctor (PCP or Specialist Physician) or a hospital is no longer with Molina, we will send You a letter to let You know. The letter will tell You how the change affects You. If Your PCP is no longer with Molina Healthcare, You can choose a different doctor. If You want a different doctor, You can choose one. Our Customer Support Center staff can help You make a choice.

If You are assigned to a PCP or hospital that is ending a contract with Molina, then Molina will provide You sixty (60) calendar days advance written notice of such a contract ending between Molina and PCP or acute care hospital. If You have been getting care from a doctor or hospital that is ending a contract with Molina Healthcare, You may have a right to keep the same doctor or get care at the same hospital for a given time period. Please contact Molina Healthcare's Customer Support Center. If You have further questions, You are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, at its toll-free number, 1 (888) HMO-2219 (1-888-466-2219) or TDD number for the deaf or hard of hearing, toll-free, at 1 (877) 688-9891, or online at www.hmohelp.ca.gov.

Continuity of Care
If You are undergoing treatment for one of the conditions listed below and Your doctor or the hospital that You were getting treatment from is no longer a Participating Provider with Molina Healthcare, You may ask Molina Healthcare's permission to stay with the doctor or hospital You are now seeing for continuity of care.

The following conditions may be eligible for continuity of care:

- You have a serious chronic condition. "**Serious Chronic Condition**" means a medical condition due to a disease, illness, or other medical problem or disorder that is serious in nature, and that does either of the following:
  - Persists without full cure or worsens over an extended period.
  - Requires ongoing treatment to maintain remission or prevent getting worse.

  If You have a Serious Chronic Condition, You may be able to stay with the doctor or hospital for up to 12 months.
- You are pregnant. You may stay with the doctor or hospital for the length of Your pregnancy. The length of Your pregnancy includes the three trimesters of pregnancy and the immediate postpartum period.
- You have an acute condition. "**Acute Condition**" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. You may stay with the doctor or hospital for the length of the acute condition.
- Your child is a newborn or child up to age 36 months. Your child may stay with the doctor or hospital for up to 12 months.
- You have a terminal illness. You may stay with the doctor or hospital for the length of the illness.
- You have received Prior Authorization for a surgery or other procedure to be performed within one-hundred-eighty (180) calendar days of the date Your doctor or hospital will no longer be with Molina Healthcare.

Eligibility for continuity of care is not based strictly upon the name of Your condition.

Your doctor or the hospital may not agree to continue to provide You services or may not agree to comply with Molina Healthcare's contractual terms and conditions that are imposed on Participating Providers. If that happens, Molina Healthcare will assign You to a new doctor or send You to a new hospital for care.

If You want to request that You stay with the same doctor or hospital for continuity of care, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-2150. If You are deaf or

hard of hearing, call Our dedicated TTY line dial 711 for the Telecommunications Service. You can also ask for a copy of Molina's policy that talks about staying with a doctor or hospital.
If you are a newly enrolled Member and your prior coverage was terminated because Your prior plan withdrew that product from the market or the plan ceased to sell products in the market between December 1, 2015 – March 31, 2016 the right to temporary continuity of care, as described above, does apply.

24-Hour Nurse Advice Line
If You have questions or concerns about You or Your family's health, call Our 24-Hour Nurse Advice Line at 1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537 **or if You are deaf or hard of hearing, You can access Nurse Advice with the Telecommunications Service. Call by dialing 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.**

Your doctor's office should give You an appointment for the listed visits in this time frame:

Appointment Type For PCPs	When You should get the appointment
Urgent care appointments for Covered Services when Prior Authorization is requested	Within 96 hours of the appointment request
Urgent care appointments for Covered Services when Prior Authorization is not requested	Within 48 hours of the appointment request
Routine or non-urgent care appointments	Within 10 working days of the appointment request
Non-urgent care with a non-physician behavioral health care provider appointments	Within 10 working days of the appointment request
Appointment Type For Specialist Physicians	When You should get the appointment
Urgent care appointments for Covered Services when Prior Authorization is requested	Within 96 hours of the appointment request
Urgent care appointments for Covered Services when Prior Authorization is not requested	Within 48 hours of the appointment request
Routine or non-urgent care appointments	Within 15 working days of the appointment request

PRIOR AUTHORIZATION

What is a Prior Authorization?
A **Prior Authorization** is a request for You to receive a Covered Service from Your doctor. Molina's Medical Directors and Your doctor all work together. They decide on the Medical Necessity before the care or service is given. This is to ensure it is the right care for Your specific condition.

You do not need Prior Authorization for the following services:

- Diagnosis or treatment plan for Autism Spectrum Disorder
- Emergency or Urgent Care Services
- Family planning services
- Human Immunodeficiency Virus (HIV) testing & counseling
- Mental health and substance abuse outpatient services, other than the following:
- Day Treatment,
- Electroconvulsive Therapy (ECT),
- Intensive Outpatient Programs (IOP),
- Mental Health Inpatient,
- Neuropsychological and Psychological Testing,
- Partial hospitalization
- Office - based procedures
- To see an OB/GYN (Women may self-refer)

You must get Prior Authorization for the following services, except for Emergency Services or Urgent Care Services:

- Admission in a hospital or ambulatory care center for dental care.
- All inpatient admissions
- Acupuncture services
- Approved clinical trials
- Bariatric surgery referral and surgery Certain Ambulatory Surgery Center service (ASC)*
- Certain Durable Medical Equipment*
- Certain injectable drugs And medications not listed on the Molina Drug Formulary*
- Certain outpatient hospital service*
- Certain Mental Health Services*
- Day treatment,
- Electroconvulsive Therapy (ECT),
- Intensive Outpatient Programs (IOP),
- Mental Health Inpatient,
- Neuropsychological and psychological testing,
- Partial hospitalization
- Cosmetic, plastic and reconstructive procedures (in any setting)
- Custom orthotics, custom prosthetics, and braces. Examples are:
- Any kind of wheelchair
- Implanted hearing device
- Scooters
- Shoes or shoe supports
- Special braces
- Dialysis (notification only)
- Drug quantities that exceed the day-supply limit
- Experimental and Investigational procedures

- General anesthesia for dental care in Members 5 years old or older
- Habilitative Services – After 6 visits for outpatient and home settings
- Home health care - After 6 visits for outpatient and home settings
- Hospice inpatient care (notification only)
- Hyperbaric Therapy
- Imaging and special tests Examples are:
- CT (computed tomography)
- MRI (magnetic resonance imaging)
- MRA (magnetic resonance angiogram)
- PET (positron emission tomography) scan
- Pain management care and procedures
- Pregnancy and delivery (notification only)
- Radiation therapy and radio surgery
- Rehabilitative services
- Cardiac and pulmonary rehabilitation
- Occupational Therapy (After 6 visits for outpatient and home settings)
- Physical Therapy (After 6 visits for outpatient and home settings)
- Speech Therapy (After 6 visits for outpatient and home settings)
- Services Rendered by a Non-Participating Provider
- Specialty pharmacy drugs (oral and injectable)
- Transplant evaluation and related service including Solid Organ and Bone Marrow (Cornea transplant does not require authorization)
- Space maintainers under Pediatric Dental Preventive Service benefit
- Braces are covered with Prior Authorization when Medically Necessary
- Retainers are covered with Prior Authorization
- Transportation. This is for non-emergent must be medically necessary. Examples are special vans service or ambulance.
- Wound Therapy

Any other services listed as needing Prior Authorization in this EOC.

*Call Molina's Customer Support Center at 1 (888) 858-2150 if You need to find out if, Your service needs Prior Authorization.

Molina Healthcare might deny a request for a Prior Authorization. You may appeal that decision as described below. If You and Your provider decide to proceed with service that has been denied You may have to pay the cost of those services.

Approvals are given based on Medical Necessity. We are here to help you, if You have questions about how a certain service is approved, call us. The number is**1 (888)** 858-2150. If You are deaf or hard of hearing, dial 711 for the Telecommunications Service.

We can explain to You how that type of decision is made. We will send You a copy of the approval process if You request it.
Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination, and no longer than fourteen (14) calendar days from the receipt of the request. Medical conditions that may cause a serious threat to Your health are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by Molina Healthcare to make the determination or, if shorter, the period of time required under Section 2719 of the federal Public Health Services Act and subsequent rules and regulations issued thereunder. Molina Healthcare processes requests for urgent specialty services immediately by telephone.

If a service request is not Medically Necessary it may be denied. If it is not a Covered Service it may be denied. You will get a letter telling You why it was denied. You or Your doctor may appeal the decision. The denial letter will tell You how to appeal. These instructions are in the s "on pages 88-91 of this EOC.

Standing Approvals
You may have a condition or disease that requires special medical care over a long period of time. You may need a standing approval. Your condition or disease may be life threatening. It may worsen. It could cause disability. If this is true You may need a standing approval to a specialist physician. You may need one for a specialty care center. They have the expertise to treat Your condition.

To get a standing approval, call Your Primary Care Doctor. Your Primary Care Doctor will work with Molina's doctors and specialist physicians to be sure Your treatment plan meets Your medical needs. If You have trouble getting a standing approval, call Us. The number is toll-free 1 (888) 858-2150 or for the. For deaf or hard of hearing dial 711 for the Telecommunications Service.

If You feel Your needs have not been met please see Molina's grievance process These instructions are in the "Complaints and Appeals" section.

Second Opinions
You or Your PCP may want a second doctor to review Your condition. This can be a PCP or a specialist physician. This doctor looks at Your medical record. The doctor may see You at their office. This new doctor may suggest a plan of care. This is called a second opinion. Please consult Your Provider Directory on Our website. You can find a Provider for a second opinion. The website is www.molinahealthcare.com/marketplace and click Find a Provider.

Here are some reasons why You may get a second opinion:

- Your symptoms are complex or confusing.
- Your doctor is not sure the diagnosis is correct.
- You have followed the doctor's plan of care and Your health has not improved.
- You are not sure if You need surgery.
- You do not agree with what Your doctor thinks is Your problem.
- You do not agree with Your doctor's plan of care.
- Your doctor has not answered Your concerns about Your diagnosis or plan of care.
- There may be other reasons.

Call Us if You have questions.

EMERGENCY SERVICES AND URGENT CARE SERVICES

What is an Emergency?
Emergency Services are services needed to evaluate, stabilize, or treat an Emergency Medical Condition. An Emergency Condition includes:

- A medical condition with acute and severe symptoms. This includes severe pain.
- A psychiatric condition with acute and severe symptoms
- Active labor
- If medical attention is not received right away, an Emergency could result in:
    - Placing the patient's health in serious danger.
    - Serious damage to bodily functions.
    - Serious dysfunction of any bodily organ or part.
    - Disfigurement to the person.

Emergency Care also includes Emergency contraceptive drug therapy.

Emergency Care includes Urgent Care Services that cannot be delayed. This is needed to prevent serious deterioration of health from an unforeseen condition or injury.

How do I get Emergency Care?
Emergency care is available twenty-four (24) hours a day, seven (7) days a week for Molina Members.

If You think You have an Emergency:

- Call 911 right away.
- Go to the closest hospital or emergency room.

When You go for Emergency health care services, bring Your Molina Member ID card.

If You are not sure if You need Emergency care but You need medical help, call Your PCP. Alternatively, call Our 24-Hour Nurse Advice Line toll-free at:

- English 1 (888) 275-8750 or,
- Spanish, 1 (866) 648-3537

The Nurse Advice Line is staffed by registered nurses (RNs). You can call the Nurse Advice Line 24 hours a day, 365 days a year. If You are deaf or hard of hearing please use the Telecommunications Service by dialing 711.

Hospital Emergency rooms are only for real emergencies. These are not good places to get Non-Emergency Services. They are often very busy and must care first for those whose lives are in danger. Please do not go to a hospital emergency room if Your condition is not an Emergency.

If You are away from Molina Healthcare's Service Area and need Emergency Care
Go to the nearest emergency room for care. Please contact Molina within 24 hours or as soon as You can. Call toll-free at 1 (888) 858-2150. If You are deaf or hard of hearing, dial 711 for the Telecommunication Relay Service.

- Tell us if You called 911 or
- Tell us if You accessed Emergency health care.

You may ask the hospital or Emergency room staff to call Molina Healthcare for You.
call Our TTY line toll-free at 1 (888) 858-2150. . When You are away from Molina's Service Area only Urgent Care Services or Emergency Services are covered.

What if I need after-hours care or Urgent Care Services?
Urgent Care Services are available when You are within or outside of Molina's Service Area. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury.

If You get ill after hours or need Urgent Care Services call Your PCP or Molina's 24-Hour Nurse Advice Line. The number is toll-free:

- English 1 (888) 275-8750
- Spanish 1 (866) 648-3537

Our nurses can help You any time of the day or night. They will help You decide what to do. They can help You decide where to go to be seen.

If You are within Molina's Service Area You can ask Your PCP what urgent care center to use. It is best to find out the name of the urgent care center ahead of time. Ask Your doctor for the name of the urgent care center and the name of the hospital that You are to use.

If You are outside of Molina's Service Area You may go to the nearest urgent care center or emergency room.

You have the right to interpreter services at no cost. To help in getting after hours care call toll-free at 1 (888) 858-2150.

Emergency Services by a Non-Participating Provider
Emergency Services for treatment of an Emergency Medical problem are subject to cost sharing. This is true whether from Participating Providers or Non-Participating Providers. See Cost Sharing for Emergency Services in the Benefits and Coverage Guide. You are financially responsible for the cost of non- covered, non-authorized services received from a nonparticipating provider following stabilization of an emergency medical condition.

COMPLEX CASE MANAGEMENT

What if I have a difficult health problem?
Living with health problems can be hard. Molina has a program that can help. The Complex Case Management program is for Members with difficult health problems. It is for those who need extra help with their health care needs.

The program allows You to talk with a nurse about Your health problems. The nurse can help You learn about those problems. The nurse can teach You how to manage them. The nurse may also work with Your family or caregiver to make sure You get the care You need. The nurse also works with Your doctor. There are several ways You can be referred for this program. There are certain requirements that You must meet. This program is voluntary. You can choose to be removed from the program at any time.

If You would like information about this program, please call the Customer Support Center toll free at 1 (888) 858-2150 or for the deaf or hard of hearing dial 711 for the Telecommunications Service.

PREGNANCY

What if I am pregnant?
If You are pregnant, or think You are pregnant, or as soon as You know You are pregnant, please call for an appointment to begin Your prenatal care. Early prenatal care is very important for the health and well-being of You and Your baby.

You may choose any of the following for Your prenatal care:

- Licensed Obstetrician-gynecologists (OB/GYNs)
- Certified Nurse Practitioner (trained in women's health)
- Certified Nurse Midwife

You can make an appointment for prenatal care without seeing Your PCP first. To receive benefits, You must pick an OB/GYN or Certified Nurse Practitioner who is a Participating Provider.

If You need help choosing an OB/GYN, call Us. If You have any questions, call Molina toll-free at 1 (888) 858-2150, We are here Monday through Friday from 8:00 a.m. to 6:00 p.m. We will be happy to help You.

Molina offers a special program called Motherhood Matters. This program provides important information about diet, exercise and other topics about pregnancy. For more information, call the Motherhood Matters pregnancy program. The toll-free number is 1 (877) 665-4628. We are here Monday through Friday, 8:00 a.m. to 6:00 p.m..

Moral Objections
Some hospitals and providers may not provide some of the services that may be covered under this EOC that You or Your family member might need: family planning, birth control, including emergency contraception, sterilization, (including tubal ligation at the time of labor and delivery), or abortion. You should obtain more information before You enroll. Call Your doctor, medical group, or clinic, or call the Customer Support Center toll-free at 1 (888) 858-2150 to make sure that You can get the health care services that You need.

Advance Directive

An Advance Directive is a form that tells medical providers what kind of care You want if You cannot speak for Yourself. An Advance Directive is written before You have an emergency. This is a way to keep other people from making important health decisions for You if You are not well enough to make Your own. A "Durable Power of Attorney for Health Care" or "Natural Death Act Declaration" is types of Advance Directives. You have the right to complete an Advance Directive. Your PCP can answer questions about Advance Directives.

You may call Molina Healthcare to get information regarding State law on Advance Directives, and changes to Advance Directive laws. Molina Healthcare updates advanced directive information no later than ninety (90) calendar days after receiving notice of changes to State laws.

For more information, call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-2150. If You are deaf or hard of hearing, dial 711 for the Telecommunication Service.

ACCESS TO CARE FOR MEMBERS WITH DISABILITIES

Americans with Disabilities Act
The Americans with Disabilities Act (ADA) prohibits discrimination based on disability. The ADA requires Molina and its contractors to make reasonable accommodations for patients with disabilities.

Physical Access
Molina has made every effort to ensure that Our offices and the offices of Molina doctors are accessible to persons with disabilities. If You are not able to locate a doctor who meets Your needs, please call Us at 1 (888) 858-2150 or for the deaf or hard of hearing dial 711 for the Telecommunication Service and a Customer Support Center Representative. We will help You find another doctor.

Access for the Deaf or Hard of Hearing
Let us know if You need a sign language interpreter at the time You make Your appointment. Molina Healthcare requests at least 72 hours advance notice to arrange for services with a qualified interpreter. Call Molina Healthcare's Customer Support Center by dialing 711 and using a Telecommunication Service.

Access for Persons with Low Vision or who are blind
You can request this EOC and other important plan materials in accessible formats. These are for persons with low vision or who are blind. Large print and enlarged computer disk formats are available. This EOC is also available in an audio format. For accessible formats, or for direct help in reading the EOC and other materials, please call Us Members who need information in large size print, audio, and Braille can ask for it. Call the Customer Support Center. The number is toll-free at 1 (888) 858-2150.

Disability Access Grievances
If You believe Molina or its doctors have failed to respond to Your disability access needs, You may file a grievance

Molina Healthcare's Bridge2Access ProgramSM
(Access Services for Seniors and People with Disabilities)
Health and wellness is the same for persons with or without disabilities and activity limitations. The Bridge2Access Program is designed to improve access to healthcare services. We will help You find a doctor that meets Your access needs. We will also provide a sign language interpreter or information in Braille, audio, large font or electronic formats at no cost to You. Contact the Customer Support Center at 1 (888) 858-2150; or use the California Relay Service at 711 to get a sign language interpreter or to get Your health care information in an accessible format. For more information look us up online at www.molinahealthcare.com.

Bridge2Access Connections
If You have questions about the access services available under Our Bridge2Access Program or need information on local resources that may be able to provide services to enhance independent living, contact the Bridge2Access Connections Hotline toll-free at 1 (877) MOLINA7 (1-877-655-4627) or Video Phone at (562) 283-6100. We will help You navigate Your health care services or connect You with one of Our community partners.

BENEFITS AND COVERAGE

Molina Healthcare covers the services described in the section titled "What is Covered Under My Plan?" below. These services are subject to the exclusions, limitations, and reductions set forth in this EOC, only if all of the following conditions are satisfied:

- You are a Member on the date that You receive the Covered Services
- Except for preventive care and services, the Covered Services are Medically Necessary
- The services are listed as Covered Services in this EOC
- You receive the Covered Services from Participating Providers inside Our Service Area for this product offered through Covered California, except where specifically noted to the contrary in this EOC. For example, in the case of an Emergency or need for out-of-area Urgent Care Services, You may receive covered services from outside providers.

The only services Molina Healthcare covers under this EOC are those described in this EOC, subject to any exclusions, limitations, and reductions described in this EOC. If You believe that health care service have been improperly denied, modified, or delayed, You may appeal the decision including and up to requesting independent medical review by the Department of Managed Health Care, as described on pages 90-91.

COST SHARING (MONEY YOU WILL HAVE TO PAY TO GET COVERED SERVICES)

Cost Sharing is the Deductible, Copayment, or Coinsurance that You must pay for Covered Services under this Agreement. The Cost Sharing amount You will be required to pay for each type of Covered Service is listed in the Molina Healthcare of California Benefits and Coverage Guide at the beginning of this EOC.

You must pay Cost Sharing for Covered Services, except for preventive services included in the Essential Health Benefits (as required by the Affordable Care Act) that are provided by Participating Providers. Cost Sharing for Covered Services is listed in the Molina Healthcare of California Benefits and Coverage Guide at the beginning of this EOC. Cost Sharing towards Essential Health Benefits may be reduced or eliminated for certain eligible Members, as determined by Covered California.

YOU SHOULD REVIEW THE MOLINA HEALTHCARE OF CALIFORNIA BENEFITS AND COVERAGE GUIDE CAREFULLY. YOU NEED TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

For Individuals - is the maximum amount of Cost Sharing You, as an individual Member, will have to pay for Covered Services in a calendar year. The Cost Sharing and individual Annual Out-of-Pocket Maximum amounts applicable to Your Certificate are specified in the Molina Healthcare of California, Inc. Benefits and Coverage Guide. For this Certificate, Cost Sharing includes payments You make towards any Deductibles, Copayments, or Coinsurance. Once Your total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Your Covered Services for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the individual Annual Out-of-Pocket Maximum.

For Family (2 or more Members) – is the maximum amount of Cost Sharing that a Family of at least two or more Members will have to pay for Covered Services in a calendar year. An individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. The Cost Sharing and family Annual Out-of-Pocket Maximum amounts applicable to Your EOC are specified in the Molina Healthcare of California, Inc. Benefits and Coverage Guide. For this EOC, Cost Sharing includes payments You or other family members enrolled as Members under this EOC make towards any Deductibles, Copayments, or Coinsurance. Once the total Cost Sharing made by at least two or more Members of a family reaches the specified Annual Out-of-Pocket Maximum amount, we will pay 100% of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year. Amounts that You pay for services that are not Covered Services under this Certificate will not count towards the family Annual Out-of-Pocket Maximum.

Coinsurance

Coinsurance is a percentage of the charges for Covered Services You must pay when You receive Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. Coinsurances are listed in the Molina Healthcare of California Benefits and Coverage Guide. Some Covered Services do not have Coinsurance They may apply a Deductible or Copayment.

Copayment

A Copayment is a specific dollar amount You must pay when You receive Covered Services. Copayments are listed in the Molina Healthcare of California Benefits and Coverage Guide. Some Covered Services do not have a Copayment. They may apply a Deductible or Coinsurance.

Deductible

"**Deductible**" is the amount You must pay in a calendar year for Covered Services You receive before Molina Healthcare will cover those services at the applicable Copayment or Coinsurance. The amount that You pay towards Your Deductible is based on the rates that Molina Healthcare has negotiated with the Participating Provider. Deductibles are listed in the Molina Healthcare of California Benefits and Coverage Guide.

Please refer to the Molina Healthcare of California Benefits and Coverage Guide to see what Covered Services are subject to the Deductible and the Deductible amount. Your product may have separate Deductible amounts for specified Covered Services. If this is the case, amounts paid towards one type of Deductible cannot be used to satisfy a different type of Deductible.

When Molina Healthcare covers services at "no charge" subject to the Deductible and You have not met Your Deductible amount, You must pay the charges for the services. When preventive services covered by this Agreement are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services.
There may be a Deductible listed for an individual Member and a Deductible for an entire family. If You are a Member in a family of two or more Members, You will meet the Deductible either:

- When You meet the Deductible for the individual Member; or
- When Your family meets the Deductible for the family.

For example, if You reach the Deductible for the individual Member, You will pay the applicable Copayment or Coinsurance for Covered Services for the rest of the calendar year, but every other Member in Your family must continue to pay towards the Deductible until Your family meets the family Deductible.

General Rules Applicable to Cost Sharing
All Covered Services have a Cost Sharing, unless specifically stated, or You meet the Annual Out-of-Pocket Maximum. Please refer to the Molina Healthcare of California Benefits and Coverage Guide at the beginning of this EOC. You will be able to determine the Cost Sharing amount You will be required to pay for each type of Covered Service listed.

You are responsible for the Cost Sharing in effect on the date You receive Covered Services, except as follows:

If You are receiving covered inpatient hospital or skilled nursing facility services on the Effective Date of this EOC, You pay the Cost Sharing in effect on Your admission date. You will pay this Cost Sharing until You are discharged. The services must be covered under Your prior health plan evidence of coverage. You must also have had no break in coverage. However, if the services are not covered under Your prior health plan evidence of coverage You pay the Cost Sharing in effect on the date You receive the Covered Services. In addition, if there has been a break in coverage, You pay the Cost Sharing in effect on the date You receive the Covered Services.

For items ordered in advance, You pay the Cost Sharing in effect on the order date. Molina will not cover the item unless You still have coverage for it on the date You receive it. You may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Receiving a Bill
In most cases, Participating Providers will ask You to make a payment toward Your Cost Sharing at the time You check in. This payment may cover only portions of the total Cost Sharing for the Covered Services You receive. The Participating Provider will bill You for any additional Cost Sharing amounts that are due. The Participating Provider is not allowed to bill You for Covered Services You receive other than for Cost Sharing amounts that are due under this EOC. However, You are responsible for paying charges for any health care services or treatment, which are not Covered Services under this EOC.

How Your Coverage Satisfies the Affordable Care Act
Your Covered Services include Essential Health Benefits as required by the Affordable Care Act. If non-EHB coverage is included in Your product, those Covered Services will be set out in this EOC as well.

The Affordable Care Act provides certain rules for Essential Health Benefits. These rules tell Molina how to administer certain benefits and Cost Sharing under this EOC. For example, under the Affordable Care Act, Molina is not allowed to set lifetime limits or annual limits on the dollar value of Essential Health Benefits provided under this EOC. When EHB preventive services are provided by a Participating Provider, You will not have to pay any Cost Sharing amounts. In addition, Molina must ensure that the Cost Sharing, which You pay for all Essential Health Benefits, does not exceed an annual limit that is determined under the Affordable Care Act. For the purposes of this EHB annual limit, Cost Sharing refers to any costs, which a Member is required to pay for receipt of Essential Health Benefits. Such Cost Sharing includes, Deductibles, Coinsurance, Copayments or similar charges, but excludes Premiums, and Your spending for non-Covered Services.

Making Your Coverage More Affordable
For qualifying Subscribers, there may be assistance to help make the product that You are purchasing under this Agreement more affordable. If You have not done so already, please contact Covered California to determine if You are eligible for tax credits. Tax credits may reduce Your Premiums and/or Your Cost Sharing responsibility toward the Essential Health Benefits. Covered California also will have information about any annual limits on Cost Sharing towards Your Essential Health Benefits. Covered California can assist You in determining whether You are a qualifying Indian who has limited or no Cost Sharing responsibilities for Essential Health Benefits. Molina will work with Covered California in helping You.

Molina does not determine or provide Affordable Care Act tax credits.

What is Covered Under My Plan?
This section tells You what medical services Molina covers These are called Your Benefits and Coverage or Covered Services.

Except for preventive care and services, for a service to be covered **it must be Medically Necessary**.

You have the right to appeal if a service is denied. These instructions are in the section "

Your care must not be Experimental or Investigational. However, You may ask to be part of Experimental or Investigational care. Turn to "Experimental and Investigational care" section for information. Molina also may cover routine medical costs for Members in Approved Clinical Trials. Turn to the "Approved Clinical Trials" section to learn more.

Certain medical services described in this section will only be covered by Molina if You obtain Prior Authorization *before* seeking treatment for such services. For a further explanation of Prior Authorization and a complete list of Covered Services, which require Prior Authorization, go to the "Prior Authorization" section. However, Prior Authorization will never apply to treatment of Emergency Conditions or for Urgent Care Services.

OUTPATIENT PROFESSIONAL SERVICES

Preventive Care and Services

Preventive Services and the Affordable Care Act

Under the Affordable Care Act and as part of Your Essential Health Benefits, Molina will cover the following government-recommended preventive services, without Your paying any Cost Sharing:

- Those evidenced-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved;
- Those immunizations for routine use in children, adolescents, and adults that have, in effect, a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
- With respect to infants, children, and adolescents, such evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- With respect to women, those evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.
- All preventive care must be furnished by a Participating Provider to be covered under this Agreement. Members are responsible for 100% of charges for non-authorized, preventive services furnished by a Non-Participating Provider.

As new recommendations and guidelines for preventive care are published by the government sources identified above, they will become covered under this Agreement. Coverage will start for product years, which begin one year after the date the recommendation or guideline is issued, or on such other date as required by the Affordable Care Act. The product year, also known as a policy year for the purposes of this provision, is based on the calendar year.

If an existing or new government recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then Molina may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with the Affordable Care Act and applicable California law. These coverage limitations also are applicable to the below listed preventive care benefits.

To help You understand and access Your benefits, preventive services for adults and children that are covered under this EOC are listed below.

Preventive Services for Children and Adolescents

The following preventive care services are covered and recommended for all children and adolescents (through age 18). You will not pay Cost Sharing if services are furnished by a Participating Provider. Members are responsible for 100% of charges for non-authorized, preventive services furnished by a Non-Participating Provider.

- Well baby/child care
- Complete health history
- Physical exam including growth assessment
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment

- Basic vision screening (non- refractive)
- Dental screening (Refer to the Pediatric Dental Addendum for full range of Pediatric Dental Services)
- Speech and hearing screening
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Immunizations*
- Laboratory tests, including tests for anemia, diabetes, cholesterol and urinary tract infections
- Tuberculosis (TB) screening
- Sickle cell trait screening, when appropriate
- Health management
- Lead blood level testing (Parents or legal guardians of Members ages six months to 72 months are entitled to receive oral or written preventive guidance on lead exposure from their PCP. This includes how children can be harmed by exposure to lead, especially lead-based paint. When Your PCP does a blood lead-screening test, it is very important to follow-up and get the blood test results. Contact Your PCP for additional questions.)
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, including those provided for in the comprehensive guidelines supported by the federal Health Resources and Services Administration, are covered for Members under the age of 21.These include those with special health care needs.)
- Depression screening: adolescents
- Hemoglobinopathies screening: newborns
- Hypothyroidism screening: newborns
- Iron supplementation in children when prescribed by a Participating Provider
- Obesity screening and counseling: children
- Phenylketonuria (PKU) screening: newborns
- Gonorrhea prophylactic medication: newborns
- Alcohol and Drug Use assessments for adolescents
- Autism screening for children 18-24 months Behavioral health assessment for children (note that Cost Sharing and additional requirements apply to Mental Health benefits beyond a behavioral health assessment)
- Cervical dysplasia screening: sexually active females
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- Hematocrit or hemoglobin screening
- HIV screening: adolescents at higher risk
- Behavioral health assessment for children
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- Hepatitis B screening for adolescents at high risk for infection

*If You take Your child to Your local health department, or the school has given Your child any shot(s), make sure to give a copy of the updated shot record (immunization card) to Your child's PCP.

Preventive Services for Adults and Seniors

The following outpatient preventive care services are covered and recommended for all adults, including seniors. You will not pay any Cost Sharing if You receive services from a Participating Provider. Members are responsible for 100% of charges for services furnished by a Non-Participating Provider.

- Medical history and physical exam
- Blood pressure check
- Cholesterol check
- Breast exam for women (based on Your age)
- Screening Mammogram for women (Low-dose mammography screenings must be performed at designated approved imaging facilities based on Your age. At a minimum, coverage shall include one baseline mammogram for persons between the ages of 35 through 39; one mammogram biennially for persons between the ages of 40 through 49; and one mammogram annually for persons of age 50 and over.)
- Cytological Screening (pap smear) for women beginning no later than age 18 (also based on Your health status and medical risk.)
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Prostate specific antigen testing
- Tuberculosis (TB) screening
- Colorectal cancer screening (based on Your age or increased medical risk)
- Cancer screening
- Osteoporosis screening for women (based on Your age)
- Immunizations
- Laboratory tests for diagnosis and treatment (including diabetes and STD's)
- Health management and chronic disease management
- Diabetes education and self-management training provided by a certified, registered or licensed health care professional (This is limited to: Medically Necessary visits upon the diagnosis of diabetes; visits following a physician's diagnosis that represents a significant change in the Member's symptoms or condition that warrants changes in the Member's self-management; visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and medical nutrition therapy related to diabetes management.)
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Bacteriuria screening: pregnant women
- Folic acid supplementation
- Hepatitis B screening: pregnant women
- Hepatitis B screening for adults at high risk for infection
- Breastfeeding support, supplies counseling
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Screening for gestational diabetes
- Hearing screenings
- Abdominal aortic aneurysm screening: men
- Alcohol misuse counseling
- Anemia screening: women
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Low-dose aspirin use for pregnant women who are at high risk for preeclampsia
- BRCA counseling about breast cancer preventive medication
- Chlamydial infection screening: women

- Depression screening: adults
- Dietary evaluation and nutritional counselingSTDs and HIV screening and counseling
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Syphilis screening and counseling (all adults at high risk)
- Gonorrhea screening and counseling (all women at high risk)
- Screening for hepatitis B virus infection in persons at high risk for infection.
- Tobacco use counseling and interventions
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed)
- Screening and counseling for interpersonal and domestic violence: women
- Obesity screening and counseling: offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.

Services of Physicians and Other Practitioners
We cover the following outpatient services when furnished by a Participating Provider physician or Other Practitioner (within the scope of his or her license):

- Prevention, diagnosis, and treatment of illness or injury
- Office visits (including pre- and post-natal visits)
- Routine pediatric and adult health exams
- Specialist consultations when referred by Your PCP (for example, a heart doctor or cancer doctor)
- Injections, allergy tests and treatments when provided or referred by Your PCP
- Audiology and hearing tests
- Physician and other Practitioner care in or out of the hospital
- Consultations and well child care
- Outpatient maternity care (including complications of pregnancy and Medically Necessary at home care)
- Outpatient newborn care as described in "Newborn and Adopted Children Coverage" under this "What is Covered Under My Plan?"
- Routine examinations and prenatal care provided by an OB/GYN to female Members. You may select an OB/GYN as Your PCP. Female Dependents age 13 and older have direct access to obstetrical and gynecological care.

Acupuncture Services
We cover acupuncture services that are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Outpatient Other Practitioner Care Cost Sharing will apply.

Habilitative Services
Medically Necessary habilitative services and devices are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Rehabilitative Services
We cover Medically Necessary rehabilitative services that help injured or disabled Members resume activities of daily living. The goal of these services is for the Member to resume routine activities of daily life usually requiring physical therapy, speech therapy, and occupational therapy in a setting appropriate for the level of disability or injury, and include cardiac and pulmonary rehabilitation.

Outpatient Mental/Behavioral Health Services
We cover the following outpatient mental health service when provided by Participating Providers who are physicians or Other Practitioners acting within the scope of their license and qualified to treat mental illness:

- Individual, family and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder (defined below)
- Outpatient services for the purpose of monitoring drug therapy
- Post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan

We cover outpatient mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is identified in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM). The "mental disorder" results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder".

"**Mental Disorders**" include the following conditions and those defined in the DSM that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

Severe Mental Illness of a person of any age. "**Severe Mental Illness**" includes the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the DSM, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code
- Pervasive Developmental Disorder or Autism, provided that the treatment develops or

restores to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The treatment is prescribed by a Participating Provider physician, or is developed by a Participating Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Participating Provider who is a Qualified Autism Service Provider (see definition below)
- The treatment is administered by a Participating Provider who is one of the following:

    - A Qualified Autism Service Provider
    - A Qualified Service Professional (see definition below) supervised and employed by the Qualified Autism Service Provider
    - A Qualified Autism Service Paraprofessional (see definition below) supervised and employed by a Qualified Autism Service Provider

- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider do all of the following:

    - Describe the Member's behavior health impairments to be treated
    - Design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goals and objectives, and the frequency at which the Member's progress is evaluated an reported
    - Provide intervention plans that utilize evidence based practices, with demonstrated clinical efficacy in treating pervasive development disorder or autism
    - Discontinue intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate

A "**Qualified Autism Service Provider**" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:

- A person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
- A person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist.

A "**Qualified Autism Service Professional**" means a person who meets all of the following criteria:

- provides behavioral health treatment
- is employed and supervised by a Qualified Autism Service Provider
- provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- is a behavioral health treatment provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
- has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

A "**Qualified Autism Service Paraprofessional**" means an unlicensed and uncertified individual who meets all of the following criteria:

- is employed and supervised by a Qualified Autism Service Provider
- provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
- meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
- Have adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

Outpatient Substance Abuse Disorder Services
We cover the following outpatient care for treatment of substance abuse:

- Day treatment programs
- Intensive outpatient programs
- Individual, family and group substance abuse counseling
- Medical treatment for withdrawal symptoms
- Individual substance abuse evaluation and treatment
- Group substance abuse treatment
- Post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan

We do not cover services for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Substance Abuse Disorder Services" section.

Dental and Orthodontic Services
We do not cover most dental and orthodontic services. We do cover some dental and orthodontic services for Members as described in this "Dental and Orthodontic Services" section.

Dental Services for Radiation Treatment
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer and other neoplastic diseases in Your head or neck. You must receive services from a Participating Provider physician.

Dental Anesthesia
For dental procedures, we cover general anesthesia and the Participating Provider facility's services associated with the anesthesia if one of the following is true:

- The Member has physical, intellectual, or medically compromising conditions for which treatment under local anesthesia cannot be expected to provide a successful result. In addition, dental treatment under general anesthesia can be expected to produce superior results.
- Members for whom local anesthesia is ineffective because of acute infection, anatomic variation, or allergy.
- Covered Dependent children or adolescents who are extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment cannot be postponed or deferred. In addition, lack of treatment for these children or adolescents can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity. (Children under 7 years of age are not required to meet any of these conditions.)
- Members with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- Other procedures for which hospitalization or general anesthesia in a hospital or ambulatory surgical center is Medically Necessary.

We do not cover any other services related to the dental procedure, such as the dentist's services.

Dental and Orthodontic Services for Cleft Palate
We cover some dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic services. They must meet all of the following requirements:

- The services are integral basic part of a reconstructive surgery for cleft palate.
- A Participating Provider provides the services; or
- Molina authorizes a Non-Participating Provider who is a dentist or orthodontist to provide the services.

Services to Treat Temporomandibular Joint Syndrome ("TMJ")
We cover the following services to treat temporomandibular joint syndrome (also known as "TMJ"):

- Medically Necessary medical non-surgical treatment of TMJ (e.g., splint and physical therapy).
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed.

For Covered Services related to dental or orthodontic care in the above sections, You will pay the Cost Sharing You would pay if the services were not related to dental or orthodontic care. For example, for inpatient hospital services, You would pay the Cost Sharing in the "Inpatient Hospital Services" section of the Molina Healthcare of California Inc. Benefits and Coverage Guide.

PEDIATRIC SERVICES

We cover the following pediatric services for Members whose age qualifies them for such services:

Pediatric Dental Services:
Molina Healthcare has partnered with California Dental Network, Inc. to administer pediatric dental benefits for Members under the age of 19 only. Molina covers Preventive/Diagnostic, Routine, Major, and Orthodontia Services as outlined in the Pediatric Dental Services addendum.

Pediatric Vision Services
Molina Healthcare covers the following vision services for Members under the age of 19:

- Routine vision screening and eye exam every calendar year.
- Prescription glasses: frames and lenses, limited to one pair of prescription glasses once every 12 months, including polycarbonate lenses.
- Contact Lenses: limited to once every 12 months, in lieu of prescription lenses and frames; includes evaluation, fitting, and follow-up care. Please refer to the section called "Specialty Vision Services" for coverage of special contact lenses for aniridia and aphakia.

Laser corrective surgery is not covered.

FAMILY PLANNING

We cover family planning services to help determine the number and spacing of children. These services include all methods of birth control approved by the FDA. As a Member, You pick a doctor who is located near You to receive the services You need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. You can do this without having to get Prior Authorization from Molina. (Molina pays the doctor or clinic for the family planning services You get.) Family planning services include:

- Health management and counseling to help You make informed choices
- Health management and counseling to help You understand birth control methods.
- Limited history and physical examination.
- Laboratory tests if medically indicated as part of deciding what birth control methods You might want to use
- Prescription birth control supplies, devices, birth control pills, including Depo-Provera
- Administration, insertion, and removal of contraceptive devices, such as intrauterine devices (IUD's)
- Follow-up care for any problems You may have using birth control methods issued by the family planning providers
- Emergency birth control supplies when filled by a contracting pharmacist, or by a non-contracted provider, in the event of an Emergency
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Pregnancy testing and counseling
- Diagnosis and treatments of sexually transmitted diseases (STDs) if medically indicated
- Screening, testing and counseling of at-risk individuals for HIV, and referral for treatment

Family Planning services do not include:

- Condoms for male use, as excluded under the Affordable Care Act

Pregnancy Terminations

- Molina Healthcare covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by any applicable California laws.

Pregnancy termination services are covered. These services are office-based procedures and do not require Prior Authorization.

If the pregnancy termination service will be provided in an inpatient setting or outpatient hospital, Prior Authorization is required.
Office Visit and Outpatient Surgery Cost Sharing will apply.

Keep in mind that some hospitals and providers may not provide pregnancy termination services.

Phenylketonuria (PKU) and other inborn errors of metabolism
We cover testing and treatment of phenylketonuria (PKU). We also cover other inborn errors of metabolism that involve amino acids. This includes formulas and special food products that are part of a diet prescribed by a Participating Provider and managed by a licensed health care professional. The health care professional will consult with a physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function.

For purposes of this section, the following definitions apply:
"Formula" is an enteral product for use at home that is prescribed by a Participating Provider.

"**Special food product**" is a food product that is prescribed by a Participating Provider for treatment of PKU. It may also be prescribed for other inborn errors of metabolism. It is used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.
(Prescription Drug Cost Sharing will apply)

Diabetes Services
We cover Medically Necessary care for Members with insulin-using diabetes, with non-insulin-using diabetes and with elevated blood glucose levels induced by pregnancy. This coverage includes the medically accepted standard of medical care for diabetes and benefits for diabetes treatment. The coverage also includes Medically Necessary equipment, supplies, and prescriptive oral agents (i.e., drugs You take by mouth) for controlling blood sugar levels. This coverage will not be reduced or eliminated.

We also cover education regarding diabetes care management.

All treatment, equipment, and supplies for diabetes care and diabetes education and management are subject to applicable Cost Sharing.

When new or improved equipment, appliances, prescription drugs, insulin, or supplies for the treatment of diabetes are approved by the U.S. Food and Drug Administration, Molina will evaluate if changes or additions to formulary/coverage under this EOC are necessary. Please contact Molina's Customer Support Center toll-free at 1 (888) 295-7651 for up-to-date information.

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient Surgery
We cover outpatient surgery services provided by Participating Providers. Services must be provided in an outpatient or ambulatory surgery center or in a hospital operating room. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Outpatient Procedures (other than surgery)
We cover some outpatient procedures other than surgery provided by Participating Providers. A licensed staff member must be required to monitor Your vital signs as You regain sensation after receiving drugs to reduce sensation or to minimize discomfort. These procedures include Medically Necessary endoscopic procedures. They also include the administration of injections and infusion therapy. Separate Cost Sharing may apply for professional services and Health Care Facility services for all outpatient procedures.

Specialized Imaging and Scanning Services
We cover Medically Necessary specialized scanning services. They include CT Scan, PET Scan, cardiac imaging, and MRI by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Radiology Services (X-Rays)
We cover Medically Necessary x-ray and radiology services, other than specialized scanning services, when furnished by Participating Providers. Separate Cost Sharing may apply for professional services and Health Care Facility services.

Chemotherapy
We cover chemotherapy when furnished by Participating Providers and Medically Necessary. Chemotherapy is subject to Cost Sharing.

Laboratory Tests
We cover the following services when furnished by Participating Providers and Medically Necessary.; These services are subject to Cost Sharing:

- Laboratory tests
- Other Medically Necessary tests, such as electrocardiograms (EKG) and electroencephalograms (EEG)
- Blood and blood plasma
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high risk pregnancy
- Alpha-Fetoprotein (AFP) screening

Mental/Behavioral Health
Outpatient Intensive Psychiatric Treatment program
We cover the following outpatient intensive psychiatric treatment programs at a Participating Provider facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility; 24-hour-a-day monitoring must be provided by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

INPATIENT HOSPITAL SERVICES

You must have a Prior Authorization to get hospital services except in the case of an Emergency or Urgent Care Services. However, if You get services in a hospital or You are admitted to the hospital for Emergency or out-of-area Urgent Care Services, Your hospital stay will be covered until You have stabilized sufficiently to transfer to a Participating Provider facility. Services provided after stabilization in an out-of-area or Non-Participating Provider facility are not Covered Services.

Medical/Surgical Services
We cover the following inpatient services in a Participating Provider hospital. These services are generally and customarily provided by acute care general hospitals inside Our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Provider physicians, including consultation and treatment by specialist physicians
- Anesthesia
- Drugs prescribed in accord with Our Drug Formulary guidelines (for discharge drugs prescribed when You are released from the hospital, please refer to "Prescription Drugs and Medications" in this "What is Covered Under My Plan?" section)
- Biologicals, fluids and chemotherapy
- Radioactive materials used for therapeutic purposes
- Durable Medical Equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Mastectomies (removal of breast) and lymph node dissections (not less than 48 hours of inpatient care following a mastectomy and 24 hours of inpatient care following a lymph node dissection for the treatment of breast cancer)
- Mastectomy-related services, including Covered Services under the "Reconstructive Surgery" section and under the "Prosthetic and Orthotic Devices" section
- Blood, blood products, and their administration
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Maternity Care
Molina covers medical, surgical and hospital care during the term of pregnancy. This includes prenatal, intrapartum and perinatal care, upon delivery for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

We cover the following maternity care services related to labor and delivery:

- Inpatient hospital care and birthing center care, including care from a Certified Nurse Midwife, for 48 hours after a normal vaginal delivery. It also includes care for 96 hours following a delivery by Cesarean section (C-section). Longer stays need to be Authorized by Molina Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Molina Healthcare of California, Inc. Benefits and Coverage Guide for the Cost Sharing that will apply to these services.
- If Your doctor, after talking with You, decides to discharge You and Your newborn before the 48 or 96 hour time period, Molina will cover post discharge services and laboratory services. (Preventive Care Cost Sharing or Primary Care Cost Sharing will apply to post discharge services, as applicable) (Laboratory Tests Cost Sharing will apply to laboratory services).

Mental/Behavioral Health
Inpatient Psychiatric Hospitalization
We cover inpatient psychiatric hospitalization in a Participating Provider hospital. Coverage includes room and board, drugs, and services of Participating Provider physicians. It also covers other Participating Providers who are licensed health care professionals acting within the scope of their license. We cover inpatient hospital mental or behavioral health services only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the most recent publication of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The mental disorder must result in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder".

"**Mental Disorders**" include the following conditions and those defined in the DSM that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the DSM identifies as something other than a "mental disorder."

Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa

A Serious Emotional Disturbance of a child under age 18. A "**Serious Emotional Disturbance**" of a child under age 18 means a condition identified as a "mental disorder" in the DSM, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment

- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Pervasive Developmental Disorder or Autism provided that the treatment develops or restores to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism

SUBSTANCE ABUSE DISORDER

Inpatient Detoxification
We cover hospitalization in a Participating Provider hospital only for detoxification and medical management of its withdrawal symptoms. This includes room and board, Participating Provider physician services, drugs, dependency recovery services, education, and counseling.

Transitional Residential Recovery Services
We cover substance abuse treatment in a nonmedical transitional residential recovery setting approved in writing by Molina. These settings provide counseling and support services in a structured environment.

Skilled Nursing Facility
We cover skilled nursing facility (SNF) services when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and board
- Physician and nursing services
- Medications
- Injections

You must have Prior Authorization for these services before the service begins. You will continue to get care without interruption. The SNF benefit is limited to 100 days per calendar year.

Hospice Care
If You are terminally ill, we cover these hospice services:

- Home hospice services
- A semi-private room in a hospice facility
- The services of a dietician
- Nursing care
- Medical social services
- Home health aide and homemaker services for outpatient care
- Physician services
- Drugs
- Medical supplies and appliances
- Respite care for up to seven days per occurrence. Respite is short-term inpatient care provided to give relief to a person caring for You
- Counseling services for You and Your family
- Development of a care plan for You
- Short term inpatient care
- Pain control
- Symptom management

- Physical therapy, occupational therapy, and speech-language therapy. We provide these therapies for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

The hospice benefit is for people who are diagnosed with a terminal illness. Terminal illness means a life expectancy of 12 months or less. They can choose hospice care instead of the traditional services covered by this product. Please contact Molina for further information. You must receive Prior Authorization for all inpatient hospice care services.

Approved Clinical Trials
We cover routine patient care costs for qualifying Members. Qualifying Members are those participating in approved clinical trials for cancer and/or another life-threatening disease or condition. You will never be enrolled in a clinical trial without Your consent. To qualify for such coverage You must:

- Be enrolled in this product
- Be diagnosed with cancer or other life threatening disease or condition
- Be accepted into an approved clinical trial (as defined below)
- Be referred by a Molina doctor who is a Participating Provider
- Received Prior Authorization or approval from Molina

For a cancer clinical trial, You need not be diagnosed with cancer. You may participate if the approved clinical trial is undertaken for the purposes of the prevention or early detection of cancer.

An approved clinical trial means a Phase I, Phase II, Phase III or Phase IV clinical trial. These trials are conducted in relation to the prevention, detection, or treatment of cancer. They may also be conducted for other life-threatening disease or condition. In addition:

- The study is approved or funded by one or more of the following: the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, or the U.S. Department of Energy; or
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and authorization requirements that apply to routine care for Members not in an approved clinical trial also apply to routine care for Members in approved clinical trials. Contact Molina or Your PCP for further information.

If You qualify, Molina cannot deny Your participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Your routine patient costs. Such costs are associated with Your participation in an approved clinical trial for which You qualify. You will not be denied or excluded from any Covered Services under this EOC based on Your health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered. They will not be covered if the approved clinical trial is for the investigation of that drug. They will also not be covered for medication that is typically provided free of charge to Members in the clinical trial.

For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service was not specifically related to an approved clinical trial. In other words, You will pay the Cost Sharing You would pay if the services were not related to a clinical trial. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of California Benefits and Coverage Guide.

Molina does not have an obligation to cover certain items and services that are not routine patient costs, as determined by the Affordable Care Act, even when You incur these costs while in an approved clinical trial. Costs excluded from coverage under Your product include:

- The investigational item, device or service itself
- Items and services solely for data collection and analysis purposes and not for direct clinical management of the patient, and
- Any service that does not fit the established standard of care for the patient's diagnosis

Bariatric Surgery
We cover hospital inpatient care related to bariatric surgical procedures. This includes room and board, imaging, laboratory, special procedures, and Participating Provider physician services. Included services are those performed to treat morbid obesity. Treatment means changing the gastrointestinal tract to reduce nutrient intake and absorption. all of the following requirements must be met to receive these services:

- You complete the medical group–approved pre-surgical educational preparatory program regarding lifestyle changes. These changes are necessary for long-term bariatric surgery success.
- A Participating Provider physician who is a specialist physician in bariatric care determines that the surgery is Medically Necessary.

For Covered Services related to bariatric surgical procedures, You will pay the Cost Sharing You would pay if the Covered Services were not related to a bariatric surgical procedure. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of California Benefits and Coverage Guide.

Reconstructive Surgery
We cover the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body. These abnormal structures may be caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either improve function, or create a normal appearance, to the extent possible, the services will be covered.
- Following Medically Necessary removal of all or part of a breast, Molina covers reconstruction of the breast. Molina will also cover surgery and reconstruction of the other breast to produce a symmetrical appearance. Molina covers treatment of physical complications, including lymphedemas.

For Covered Services related to reconstructive surgery, You will pay the Cost Sharing You would pay if the Covered Services were not related to reconstructive surgery. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of California Benefits and Coverage Guide.

Reconstructive surgery exclusions
The following reconstructive surgery services are **not** covered:

- Surgery that, in the judgment of a Participating Provider physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body to improve appearance

Transplant Services
We cover transplants of organs, tissue, or bone marrow at participating facilities. Molina must authorize services for care to a transplant facility, as described in the "Accessing Care" section, under "What is a Prior Authorization?"

After the prior authorization to a transplant facility, the following applies:

- If either the physician or the authorized Health Care Facility determines that You do not satisfy its respective criteria for a transplant, Molina will only cover services You receive before that decision is made.
- Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- In accord with Our guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor. Molina will provide services for an individual identified as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for You. This may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are available by calling Our Customer Support Center toll-free at 1 (888) 295-7651.
- Services are directly related to a covered transplant service for You or are required for evaluating potential donors, harvesting the organ, bone marrow, or stem cells, or treating complications resulting from the evaluation or donation, but not including blood transfusions or blood products.
- Donor receives Covered Services no later than ninety (90) days following the harvest or evaluation service;
- Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting;
- Donor receives written Prior Authorization for evaluation and harvesting services;
- For services to treat complications, the donor either receives non-emergency services after written Prior Authorization, or receives emergency services Molina would have covered if You had received them; and
- In the event Your coverage under this plan terminates after the donation or harvest, but before the expiration of the 90-day time limit for services to treat complications, Molina will continue to pay for Medically Necessary services for donor for 90 days following the harvest or evaluation service.

For covered transplant services, You will pay the Cost Sharing You would pay if the Covered Services were not related to transplant services. For example, for hospital inpatient care, You would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Molina Healthcare of California Benefits and Coverage Guide. Limited transplant-related travel services will be covered subject to Prior Authorization. Guidelines for transplant-related travel services are available by calling Our Customer Support Center toll-free at 1 (888) 858-2150.

Molina provides or pays for donation-related services for actual or potential donors (whether or not they are Members) in accord with Our guidelines for donor services at no charge.

PRESCRIPTION DRUG COVERAGE

We cover prescription drugs and medications, subject to applicable Cost Sharing under the following conditions:

- They are ordered by a Participating Provider treating You and the drug is listed in the Molina Healthcare Drug Formulary. Drugs approved by Molina's Pharmacy Department are also covered.
- They are ordered or given while You are in an emergency room or hospital.
- They are given while You are in a skilled nursing facility. They must be ordered by a Participating Provider in connection with a Covered Service. The prescription drugs are obtained through a pharmacy that is in the Molina pharmacy network.
- The drug is prescribed by a Participating Provider who is a family planning doctor or other provider whose services do not require an approval.

Also, subject to applicable Cost Sharing, and as prescribed by a Participating Provider:

We cover orally administered anti-cancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously or injected cancer medications.
We cover for the human papillomavirus vaccine for female Members who are nine to fourteen years of age.

We cover Tier 1, Tier 2, Tier 3, and Tier 4 drugs. Such prescription drugs must be obtained through Molina Healthcare's contracted pharmacies within California.

Prescription drugs are covered outside of the state of California (out of area) for Emergency or Urgent Care services only.

You may view a list of pharmacies and estimated range of cost for formulary drugs on Molina Healthcare's website, www.molinahealthcare.com/marketplace.

If You or Your advocate are having trouble getting a prescription filled at the pharmacy, please call Molina's Customer Support Center toll-free at 1 (888) 858-2150 for assistance. If You are deaf or hard of hearing, contact Us with the Telecommunications Service by dialing 711.

If You need an interpreter to communicate with the pharmacy about getting Your medication, call Molina Healthcare toll-free at 1 (888) 858-2150.

Molina Healthcare Drug Formulary (List of Drugs)

Molina Healthcare has a list of drugs that it will cover. The list is called the Drug Formulary. The drugs on the list are chosen by a group of doctors and pharmacists from Molina Healthcare and the medical community. The group meets every three months to talk about the drugs that are in the formulary. They review new drugs and changes in health care. They try to find the most effective drugs for different conditions. Drugs are added or removed from the Drug Formulary for different reasons. This could be:

- Changes in medical practice
- Medical technology
- When new FDA–approved drugs come on the market.
- When drugs are removed from the market by the FDA
- When a drug is identified with a new safety issue

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is www.molinahealthcare.com/marketplace. You may call Molina Healthcare and ask about a drug. Call toll free 1 (888) 858-2150, Monday through Friday and choose the pharmacy option, 8:00 a.m. through 6:00 p.m. If You are deaf or hard of hearing, dial 711 for the Telecommunications Service.

You can also ask Us to mail You a copy of the Drug Formulary. A drug listed on the Drug Formulary does not guarantee that Your doctor will prescribe it for You.

Access to Drugs Which are Not Covered
Molina has a process to allow You to request clinically appropriate drugs that are not covered under Your product. Your doctor may order a drug that is not in the Drug Formulary that he or she believes is best for You. Your doctor may contact Molina's Pharmacy Department to request that Molina cover the drug for You. If the request is approved, Molina will contact Your doctor. If the request is denied, Molina Healthcare will send a letter to You and Your doctor. The letter will explain why the drug was denied.

You may be taking a drug that is no longer on Our Drug Formulary. Your doctor can ask Us to keep covering it by sending Us a Prior Authorization request for the drug. The drug must be safe and effective for Your medical condition. Your doctor must write Your prescription for the usual amount of the drug for You**.** Molina may cover specific non-Drug Formulary drugs under the following conditions:

- Document in Your medical record;
- Certify that the Drug Formulary alternatives have not been effective in Your treatment; or
- The Drug Formulary alternatives cause or are reasonably expected by the prescriber to cause a harmful or adverse reaction in the Member.

There are two types of requests for clinically appropriate drugs that are not covered under Your product:

- Exception Request for urgent circumstances that may seriously jeopardize life, health, or ability to regain maximum function, or for undergoing current treatment using non-Drug Formulary drugs.
- Standard Exception Request.

You and/or Your Participating Provider will be notified of Our decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

If initial request is denied, You and/or Your Participating Provider may request an IRO review. You and or Your Participating Provider will be notified of the IRO's decision no later than:

- 24 hours following receipt of request for Expedited Exception Request
- 72 hours following receipt of request for Standard Exception Request

Cost Sharing for Prescription Drugs and Medications

The Cost Sharing for prescription drugs and medications is listed on the Molina Healthcare of California Benefits and Coverage Guide. Cost Sharing applies to all drugs and medications prescribed by a Participating Provider on an outpatient basis unless such drug therapy is an item of EHB preventive care administered or prescribed by a Participating Provider. This would not be subject to Cost Sharing.

Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy, and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety, efficacy, and cost or;
	3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or;
	2) Self-administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is > $600.

Tier 1

Tier 1, Cost Sharing for Formulary Tier 1 drugs is listed on the Molina Healthcare of California, Inc. Benefits and Coverage Guide You will be charged a Copayment for Tier 1 drugs.

If Your doctor orders a Tier 2 drug not on the formulary and there is a Tier 1 equivalent available, the Plan will cover the Tier 1 equivalent and the member may obtain the Tier 1 equivalent by paying the Tier 1 cost-share.

If You request, or Your doctor says You must have, the Tier 2 drug instead of the Tier 1 equivalent, Your doctor and/or You may submit a Prior Authorization request to Molina Healthcare's Pharmacy Department.
If Molina does not prior authorize the Tier 2 drug in lieu of the Tier 1 equivalent, You may obtain the Tier 2 drug but must pay the cost-share for the Tier 2 drug plus the difference in cost between the Tier 2 drug and the Tier 1 equivalent. If Molina does provide prior authorization for the Tier 2 drug in lieu of the Tier 1 equivalent, You may obtain the Tier 2 drug but must pay the Tier 2 cost- share. Cost Share maximum for Bronze 60 HMO Plan: Up to $500 per script after pharmacy deductible.

Tier 2

Tier 2, Cost Sharing for Formulary Tier 2 drugs is listed on the Molina Healthcare of California, Inc. Benefits and Coverage Guide. Deductible may apply, and You will be charged a Copayment for Formulary Tier 2 Drugs. Cost Share maximum for Bronze 60 HMO Plan: Up to $500 per script after pharmacy deductible.

Tier 3

Tier 3, Cost Sharing for Formulary Tier 3 drugs is listed on the Molina Healthcare of California, Inc. Benefits and Coverage Guide. Deductible may apply, and You will be charged a Coinsurance for Formulary Tier 3 Drugs. Cost Share maximum for Bronze 60 HMO Plan: Up to $500 per script after pharmacy deductible.

Tier 4

Tier 4, Molina Healthcare may require that Tier 4 drugs be obtained from a participating specialty pharmacy or facility for coverage. Molina Healthcare's specialty pharmacy will coordinate with You or Your physician to provide delivery to either Your home or Your provider's office. Deductible may apply, and You will be charged a Coinsurance for Tier 4 drugs. Coinsurance for Cost Share maximum for Bronze 60 HMO Plan: 100% up to $500 per script after applicable pharmacy deductible is met.

Stop-Smoking Drugs

Stop-Smoking drugs are prescription drugs within the Molina Healthcare Drug Formulary that we cover to help You stop smoking. You can learn more about Your choices by calling Molina Healthcare's Health Education Department toll-free at 1 (866) 472-9483, Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-month supply of stop smoking medication. You will also be given a phone number that You can call anytime You need help.

Mail order availability of Formulary Prescription Drugs

Molina offers You a mail order Formulary Prescription drug option. Formulary Prescriptions drugs can be mailed to You within 10 days from order request and approval. Cost Sharing is a 90- day supply applied at two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one month. In-person prescription assistance is always available at No Charge at a participating pharmacy.

You may request mail order service in the following ways:

- You can order online. Visit www.molinahealthcare.com/marketplace and select the mail order option. Then follow the prompts.
- You can call the FastStart® toll-free number at 1-800-875-0867. Provide Your Molina Member number (found on Your ID card), Your prescription name(s), Your doctor's name and phone number, and Your mailing address.
- You can mail a mail order request form. Visit www.molinahealthcare.com/marketplace and select the mail order form option. Complete and mail the form to the address on the form along with Your payment. You can give Your doctor's office the toll-free FastStart® physician number 1-800-378-5697, and ask Your doctor to call, fax, or electronically prescribe Your prescription. To speed up the process, Your doctor will need Your Molina Member number (found on Your ID card), Your date of birth, and Your mailing address.

You can opt out of Mail Order at any time. You or your advocate can call Molina's Customer Support Center toll-free at 1 (888) 858-2150 for assistance. If You are deaf or hard of hearing, contact Us with the Telecommunications Service by dialing 711.

Diabetes Supplies
Diabetes supplies, such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, glucagon emergency kits, blood glucose test strips and urine test strips are covered supplies and are provided at Coinsurance Cost Sharing to You. Pen delivery systems for the administration of insulin are also covered and are provided at the Tier 2 Cost Sharing amount found in the Molina Healthcare of California, Inc. Benefits and Coverage Guide section of this EOC.

Day Supply Limit
The prescribing Participating Provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the Participating Provider determines the amount of an item that constitutes a Medically Necessary 30-day supply for You. Upon payment of the Cost Sharing specified in this "Prescription Drug Coverage" section, You will receive the supply prescribed up to a 30-day supply in a 30-day period. Quantities that exceed the day supply limit are not covered unless Prior Authorized.

Off-Label Drug Use
Molina Healthcare covers prescription drugs and medications prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all of the following coverage criteria:

- The drug is approved by the Food and Drug Administration.
- The drug meets one of the following conditions:
  - The drug is prescribed by a participating licensed health care professional for the treatment of a life threatening condition; or
  - The drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition the drug is Medically Necessary to treat such condition and the drug is on the Recommended Drug List or Prior Authorization has been obtained for such drug.

- The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following:
  - The American Hospital Formulary Service Drug Information; or
  - One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
  - The Elsevier Gold Standard's Clinical Pharmacology.
  - The National Comprehensive Cancer Network Drug and Biologics Compendium.
  - The Thomson Micromedex DrugDex; or
  - Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal/
- The drug is otherwise Medically Necessary.

The following definitions apply to the terms mentioned in this provision only.

"Life-threatening" means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted:
- Diseases or conditions with potentially fatal outcomes, where the end of clinical intervention is survival.

"Chronic and seriously debilitating" refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity. Specialty Drug Cost Sharing and Prior Authorization rules will apply.

ANCILLARY SERVICES

Durable Medical Equipment
If You need Durable Medical Equipment, Molina Healthcare will rent or purchase the equipment for You. Prior Authorization (approval) from Molina Healthcare is required for Durable Medical Equipment. The Durable Medical Equipment must be provided through a vendor that is contracted with Molina Healthcare. We cover reasonable repairs, maintenance, delivery, and related supplies for Durable Medical Equipment. You may be responsible for repairs to Durable Medical Equipment if they are due to misuse or loss.

Covered Durable Medical Equipment includes:

- Infusion pumps and supplies to operate the pump (but not including any drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns
- Oxygen and oxygen equipment
- Apnea monitors
- Pulmoaides and related supplies
- Nebulizer machines, face masks, tubing, peak flow meters and related supplies
- Spacer devices for metered dose inhalers
- Ostomy and urological supplies.

In addition, we cover the following Durable Medical Equipment and supplies for the treatment of diabetes, when Medically Necessary:

- Blood glucose monitors designed to assist Members with low vision or who are blind
- Insulin pumps and all related necessary supplies
- Podiatric devices to prevent or treat diabetes related foot problems
- Visual aids, excluding eye wear, to assist those with low vision with the proper dosing of insulin.

Prosthetic and Orthotic Devices
We do not cover most prosthetic and orthotic devices, but we do cover internally implanted devices and external devices as described in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets Your medical needs
- You receive the device from the provider or vendor that Molina Healthcare selects

When we do cover a prosthetic and orthotic device, the coverage includes fitting and adjustment of the device, repair or replacement of the device (unless due to loss or misuse), and services to determine whether You need a prosthetic or orthotic device. If we cover a replacement device, then You pay the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices
We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, Osseo integrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Us.

For internally implanted devices, please refer to the "Inpatient Hospital Services" or "Outpatient Hospital/Facility Services" sections (as applicable) of the External devices Molina Healthcare of California, Inc. Benefits and Coverage Guide to see the Cost Sharing applicable to these devices. We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices).
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months when required to hold a prosthesis.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

For external devices, Durable Medical Equipment Cost Sharing will apply.

Hearing Services
Molina Healthcare does not cover hearing aids (other than internally implanted devices as described in the "Prosthetic and Orthotic Devices" section). However, Molina Healthcare does cover routine hearing screenings that are Preventive Care Services at No Charge.

Home Health Care
These home health care services are covered when Medically Necessary and referred by Your PCP, and approved by Molina Healthcare:

- Part-time skilled nursing services
- Nurse visits
- In-home medical care services
- Physical therapy, occupational therapy, or speech therapy
- Medical social services
- Home health aide services
- Medical supplies
- Necessary medical appliances

The following home health care services are covered under Your product:

- Up to two hours per visit for visits by a nurse, medical social worker, physical, occupational, or speech therapist and up to four hours per visit by a home health aide
- Up to 100 visits per calendar year (counting all home health visits)

You must have Prior Authorization for all home health services before obtaining services. Please refer to the "Exclusions" section of this EOC for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation
We cover Emergency Medical transportation (ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary.

Non-Emergency Medical Transportation - Ambulance
Non-emergency ambulance and psychiatric transport van services are covered if a Participating Provider determines that Your condition requires the use of services that only a licensed ambulance or psychiatric transport van can provide and that the use of other means of transportation would endanger Your health. These services are covered only when the vehicle transports You to or from Covered Services. You must have Prior Authorization from Molina Healthcare for these services before the services are given.

Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered, even if it is the only way to travel to a Participating Provider.

OTHER SERVICES

Dialysis Services
Molina Healthcare covers acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside Our Service Area
- You satisfy all medical criteria developed by Molina Healthcare
- A Participating Provider physician provides a written Referral for care at the facility

After You receive appropriate training at a Molina approved and designated dialysis facility, Molina Healthcare also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside Our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets Your medical needs. We decide whether to rent or purchase the equipment and supplies, and We select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when We are no longer covering them.

Specialty Vision Services
We cover the following special contact lenses when prescribed by a Participating Provider:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris). We will not cover an aniridia contact lens if We provided an allowance toward (or otherwise covered) more than two aniridia contact lens for that eye within the previous 12 months.
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9. We will not cover an aphakic contact lens if We provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year.

Outpatient Specialty Care Cost Sharing will apply.

EXCLUSIONS

What is Excluded from Coverage Under My Plan?
This "Exclusions" section lists specific items and services excluded from coverage under this EOC. These exclusions apply to all services that would otherwise be covered under this EOC regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "What is Covered Under My Plan?" section.

Aquatic Therapy
We do not cover aquatic therapy and other water therapy, except that this exclusion for Medically Necessary aquatic therapy and other water therapy services does not apply to therapy services that are part of a physical therapy treatment plan and covered under "Hospital Inpatient Care," "Outpatient Care," "Home Health Care," "Hospice Services," or "Skilled Nursing Facility Care" in this EOC.

Artificial Insemination and Conception by Artificial Means
All services related to artificial insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Certain Exams and Services
Physical exams and other services 1) required for obtaining or maintaining employment or participation in employee programs, 2) required for insurance or licensing, or 3) on court order or required for parole or probation. This exclusion does not apply if a Participating Provider physician determines that the services are Medically Necessary.

Chiropractic Services
Chiropractic services and the services of a chiropractor, except when provided in connection with occupational therapy and physical therapy.

Cosmetic Services
Services that are performed to alter or reshape normal structure of the body in order to improve Your appearance. Except that this exclusion does not apply to any services covered under "Reconstructive Surgery" in the "What is Covered Under My Plan?" section and devices covered under "Prosthetic and Orthotic Devices" in the "What is Covered Under My Plan?" section.

Custodial Care
Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.

Dental and Orthodontic Services
Dental and orthodontic services such as x-rays, appliances, implants, services provided by dentists or orthodontists, dental services following accidental injury to teeth, and dental services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to services covered under "Dental and Orthodontic Services" in the "What is Covered Under My Plan?" section. This exclusion does not apply to Pediatric Dental Services that are listed as Covered Services in the Pediatric Dental Services Addendum.

Dietician

A service of a dietician is not a covered benefit.

Disposable Supplies
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, under pads, and other incontinence supplies.

This exclusion does not apply to disposable supplies that are listed as covered in the "What is Covered Under My Plan?" section.

Erectile Dysfunction Drugs
Coverage of erectile dysfunction drugs unless required by state law.

Experimental or Investigational Services
Any medical service including procedures, medications, facilities, and devices that Molina Healthcare has determined have not been demonstrated as safe or effective compared with conventional medical services.

This exclusion does not apply to any of the following:

Services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan?" section

Please refer to the "Independent Medical Review" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Hair Loss or Growth Treatment
We do not cover Male Contraceptives

- Condoms are not covered

Infertility Services
Services related to the diagnosis and treatment of infertility.

Intermediate Care
Care in a licensed intermediate care facility. This exclusion does not apply to services covered under "Durable Medical Equipment", "Home Health Care", and "Hospice Care" in the "What is Covered Under My Plan?" section.

Items and Services That are Not Health Care Items and Services
Molina Healthcare does not cover services that are not health care services. example Examples of these types of services are:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching You how to read, whether or not You have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling

This exclusion does not apply to services covered for the treatment of Pervasive Developmental Disorder or Autism and defined and covered in accordance with the "Mental Health Services" section in the "What is Covered Under My Plan?"

Items and Services to Correct Refractive Defects of the Eye
Items and services (such as eye surgery or contact lenses to reshape the eye) for correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism, except those Covered Services listed under "Pediatric Vision Services" in the "What is Covered Under My Plan" section.

Massage Therapy and Alternative Treatments
We do not cover massage therapy, except that this exclusion does not apply to Medically Necessary massage therapy services that are part of a physical therapy treatment plan and listed as Covered Services in the "What is Covered Under My Product?" section.

Oral Nutrition
Outpatient oral nutrition, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Formulas and special food products when prescribed for the treatment of Phenylketonuria or other inborn errors of metabolism involving amino acids, in accordance with the" Phenylketonuria (PKU)" section of this EOC.

Private Duty Nursing Services
We do not cover private duty nursing services.

Routine Foot Care Items and Services
Routine foot care items and services which are not Medically Necessary (for example, Medically Necessary for the treatment of diabetes)

Services Not Approved by the Federal Food and Drug Administration
Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S.

This exclusion does not apply to services covered under "Approved Clinical Trials" in the "What is Covered Under My Plan" section.

Please refer to the "Independent Medical Review for Denials of Experimental/Investigational Therapies" section for information about Independent Medical Review related to denied requests for Experimental or Investigational services.

Services Performed by Unlicensed People
We do not cover services performed by people who do not require licenses or certificates by the state to provide health care services, except as otherwise provided in this EOC.

Services Related to a Non-Covered Service
When a Service is not covered, all services related to the non-Covered Service are excluded; except for services, Molina Healthcare would otherwise cover to treat complications of the non-Covered Service. For example, if You have a non-covered cosmetic surgery, Molina Healthcare would not cover services You receive in preparation for the surgery or for follow-up care. If You later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and Molina Healthcare would cover any services that Molina Healthcare would otherwise cover to treat that complication.

Surrogacy
Services for anyone in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses
Most travel and lodging expenses are not covered. Molina Healthcare may pay certain expenses that Molina Healthcare preauthorizes in accordance with Molina's travel and lodging guidelines. Molina Healthcare's travel and lodging guidelines are available from Our Customer Support Center by calling toll free 1 (888) 858-2150or for the deaf or hard of hearing dial 711 for the Telecommunications Service.

COORDINATION OF BENEFITS

This Coordination of Benefits ("**COB**") provision applies when a Member has health care coverage under more than one Plan. All of the benefits provided under This Plan Agreement are subject to this provision. For purposes of this COB provision, Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the "**Primary Plan**". The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the "**Secondary Plan**". The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Pediatric dental essential health benefits
For provision of pediatric dental essential health benefits, this Plan is considered primary.

DEFINITIONS (APPLICABLE TO THIS COB PROVISION)

A "**Plan**" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes:
   - Group, blanket, or franchise insurance coverage.
   - Service plan contracts, group practice, individual practice and other prepayment coverage,
   - Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and
   - Any coverage under governmental programs and any coverage required or provided by any statute.

2. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, program school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

- "**This Plan**" means that portion of this Agreement that provides the benefits that are subject to this COB provision and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the Member has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. When there are more than two Plans covering the Member, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

"**Allowable Expense**" is a health care expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any Plan covering the Member. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Member is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.

1. If a Member is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

2. If a Member is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

3. If a Member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans.

However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

4. The amount of any benefit reduction by the Primary Plan because a Member has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

"**Claim Determination Period**" means a calendar year.

Order of Benefit Determination Rules
(A) When a Member is covered by two or more Plans, these Order of Benefit Determination rules apply in determining the benefits as to a Member covered under This Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such Member during such period, the sum of:

(i) the value of the benefits that would be provided by This Plan in the absence of this provision, and

(ii) the benefits that would be payable under all other Plans in the absence therein of provisions of similar purpose to this provision would exceed such Allowable Expenses.

(B) As to any Claim Determination Period to which this provision is applicable, the benefits that would be provided under This Plan in the absence of this provision for the Allowable Expenses incurred as to such Member during such Claim Determination Period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such Allowable Expenses under all other Plans, except as provided in paragraph (C), shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been made therefore.

(C) If (i) another Plan which is involved in paragraph (B) and which contains a provision coordinating its benefits with those of This Plan would, according to its rules, determine its benefits after the benefits of This Plan have been determined, and (ii) the rules set forth in paragraph (D) would require This Plan to determine its benefits before such other Plan, then the benefits of such other Plan will be ignored for the purposes of determining the benefits under This Plan.

(D) For the purposes of paragraph (C), use the first of the following rules establishing the order of determination, which applies:

(1) The benefits of a Plan which covers the Member on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such Member as a dependent, except that, if the Member is also a Medicare beneficiary and as a result of the rules established by Title XVIII of the Social Security Act (42 USC 1395 et seq.) and implementing regulations, Medicare is (i) secondary to the Plan covering the Member as a dependent and (ii) primary to the Plan covering the Member as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the Member as a dependent are determined before those of the Plan covering that Member as other than a dependent.

(2) Except for cases of a Member for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a Plan which covers the Member on whose expenses claim is based as a dependent of a Member whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such Member as a dependent of a Member whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this subparagraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this subparagraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this subparagraph shall determine the order of the benefits.

(3) Except as provided in subparagraph (5), in the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a

dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

(4) Except as provided in Subparagraph (5), in the case of a Member for whom claim is made as a Dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(5) In the case of a Member for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding Subparagraphs (3) and (4), the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

(6) Except as provided in Subparagraph (7), the benefits of a Plan covering the Member for whose expenses claim is based as a laid-off or retired employee, or dependent of such Member, shall be determined after the benefits of any other Plan covering such Member as an employee, other than a laid-off or retired employee, or dependent of such Member;

(7) If either Plan does not have a provision regarding laid-off or retired employees, which results in each Plan determining its benefits after the other, then the rule under subparagraph (6) shall not apply;

(8) If a Member whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

- First, the benefits of a Plan covering the Member as an employee, member, or subscriber, or as that Member's dependent;

- Second, the benefits under continuation coverage. If the other Plan does not have the rules described above, and if, as a result, the Plans do not agree on the order of benefits, the rule under this subparagraph is ignored.

(9) When Subparagraphs (1) through (8) do not establish an order of benefit determination, the benefits of a Plan which has covered the Member on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such Member the shorter period of time.

(E) When this provision operates to reduce the total amount of benefits otherwise payable as to a Member covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

Effect On The Benefits Of This Plan
When a claim under a Plan with a COB provision involves another Plan, which also has a COB provision, the carriers involved shall use the above rules to decide the order in which the benefits payable under the respective Plans will be determined.

In determining the length of time an individual has been covered under a given Plan, two successive Plans of a given group shall be deemed to be one continuous Plan so long as the claimant concerned was eligible for coverage within 24 hours after the prior Plan terminated. Thus, neither a change in the amount or scope of benefits provided by a Plan, a change in the carrier insuring the Plan, nor a change from one type of Plan to another (e.g., single employer to multiple employer Plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new Plan for purposes of this instruction.

If a claimant's effective date of coverage under a given Plan is subsequent to the date the carrier first contracted to provide the Plan for the group concerned (employer, union, association, etc.), then, in the absence of specific information to the contrary, the carrier shall assume, for purposes of this instruction, that the claimant's length of time covered under that Plan shall be measured from claimant's effective date coverage. If a claimant's effective date of coverage under a given Plan is the same as the date the carrier first contracted to provide the Plan for the group concerned, then the carrier shall require the group concerned to furnish the date the claimant first became covered under the earliest of any prior Plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that Plan has been in force.

It is recognized that there may be existing group plans containing provisions under which the coverage is declared to be "excess" to all other coverages, or other COB provisions not consistent with this rule. In such cases, plans are urged to use the following claims administration procedures: A group plan should pay first if it would be primary under the COB order of benefits determination. In those cases where a group plan would normally be considered secondary, the plan should make every effort to coordinate in a secondary position with benefits available through any such "excess" plans. The plan should try to secure the necessary information from the "excess" plan.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Molina may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Molina any facts it needs to apply those rules and determine benefits payable. If You do not provide Us the information we need to apply these rules and determine the benefits payable, Your claim for benefits will be denied.

Facility of Payment
A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Molina may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services. To the extent of such payments, the Plan shall be fully discharged from liability under This Plan.

Right of Recovery
If the amount of the payments made by Molina is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we paid or for whom we had paid, or any other person or organization that may be responsible for the benefits or services provided for the Member. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes If You believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. Follow the steps described in the "Complaints" section, below. If You are still not satisfied, You may call the Department of Managed Health Care (DMHC) for instructions on filing a consumer complaint. Call 1 (800) 400-0815, or visit Department of Managed Health Care (DMHC) website at www.hmohelp.ca.gov.

By electing coverage or accepting benefits under this Agreement, all Members legally capable of contracting, and the legal representatives for all Members incapable of contracting, agree to all provisions of this Agreement.

Third-party liability
You agree that, if Covered Services are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, if You are made whole for all other damages resulting from the wrongful act or omission before Molina Healthcare is entitled to reimbursement, then You shall:

- Reimburse Molina Healthcare for the reasonable cost of services paid by Molina Healthcare to the extent permitted by California Civil Code section 3040 immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with Molina Healthcare’s effectuation of its lien rights for the reasonable value of services provided by Molina Healthcare to the extent permitted under California Civil Code section 3040. Molina Healthcare’s lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Molina Healthcare shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and You shall cooperate to fully and completely assist in protecting the rights of Molina Healthcare including providing prompt notification of a case involving possible recovery from a third party.

WORKERS' COMPENSATION

Molina Healthcare shall not furnish benefits under this Agreement that duplicate the benefits to which You are entitled under any applicable workers' compensation law. You are responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers compensation system can be reasonably expected. Failure to take proper and timely action will preclude Molina Healthcare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between You and the Workers' Compensation carrier, as to Your ability to collect under workers' compensation laws, Molina Healthcare will provide the benefits described in this Agreement until resolution of the dispute.

If Molina Healthcare provides benefits which duplicate the benefits You are entitled to under workers' compensation law, Molina Healthcare shall be entitled to reimbursement for the reasonable cost of such benefits.

RENEWAL AND TERMINATION

How Does my Molina Healthcare Coverage Renew?
Coverage shall be renewed on the first day of each month, upon Molina Healthcare's receipt of any prepaid Premiums due. Renewal is subject to Molina Healthcare's right to amend this EOC. You must follow the procedures required by Covered California to redetermine Your eligibility for enrollment every year during Covered California's annual open enrollment period.

Changes in Premiums, Deductibles, Copayments and Benefits and Coverage:
Any change to this Agreement, including changes in Premiums, Benefits and Coverage or Covered Services, Deductible, Copayment, Coinsurance and Annual Out-of-Pocket Maximum amounts, is effective after sixty (60) calendar days' notice to the Subscriber's address of record with Molina Healthcare.

When Will My Molina Healthcare Membership End?
(Termination of Benefits and Coverage)
The termination date of Your coverage is the first day You are not covered with Molina Healthcare (for example, if Your termination date is July 1, 2016, Your last minute of coverage was at 11:59 p.m. on June 30, 2016). If Your coverage terminates for any reason, You must pay all amounts payable and owing related to Your coverage with Molina Healthcare, including Premiums, for the period prior to Your termination date.

Except in the case of fraud or deception in the use of services or facilities, Molina Healthcare will return to You within thirty (30) calendar days the amount of Premiums paid to Molina Healthcare which corresponds to any unexpired period for which payment had been received together with amounts due on claims, if any, less any amounts due Molina Healthcare.

You may request a review by the Director of the Department of Managed Health Care if You believe that this Agreement has been or will be improperly cancelled, rescinded or not renewed. You may contact the Department of Managed Health Care at its toll-free number, 1 (888) HMO-2219 (1-888-466-2219) or TDD number for the deaf or hard of hearing, toll-free, at 1 (877) 688-9891, or online at www.hmohelp.ca.gov.

Your membership with Molina Healthcare will terminate if You:

No Longer Meet Eligibility Requirements: You no longer meet the age or other eligibility requirements for coverage under this product as required by Molina Healthcare or Covered California. You no longer live in Molina Healthcare's Service Area for this product. Covered California will send You notice of any eligibility determination. Molina Healthcare will send You notice when it learns You have moved out of the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.

- For Non-Age-Related loss of Eligibility, Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to You unless You request an earlier termination effective date.
- For a Dependent Child Reaching the Limiting Age of 26, Coverage under this Policy, for a Dependent Child, will terminate upon receiving notice from Covered California; unless the child is disabled and meets specified criteria. See the section titled "Age Limit for Children (Disabled Children).

Request Disenrollment: You decide to end Your membership and disenroll from Molina Healthcare by notifying Molina Healthcare and/or Covered California. Your membership will end at 11:59 p.m. on the fourteenth (14th) calendar day following the date of Your request or a later date if requested by You. Molina Healthcare may, at its discretion, accommodate a request to end Your membership in fewer than fourteen (14) calendar days.

Have Child-Only Coverage: Child-Only Coverage under this Policy, including coverage of dependents of Child-Only Coverage members, will terminate at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches age 21. When Child-Only Coverage under this Policy terminates because the Member has reached age 21, the Member and any Dependents may be eligible to enroll in other products offered by Molina through Covered California.

Change *Covered California* Health Plans: You decide to change from Molina Healthcare to another health plan offered through Covered California either (i) within the first sixty (60) calendar days from the Effective Date of Your coverage if You are not satisfied with Molina Healthcare, or (ii) during an annual open enrollment period or other special enrollment period for which You have been determined eligible in accordance with Covered California's special enrollment procedures, or (iii) when You seek to enroll a new Dependent. Your membership will end at 11:59 p.m. on the day before the effective date of coverage through Your new health plan.

Fraud or Misrepresentation: You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of Your coverage with Molina Healthcare, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed. Some examples include:

- Misrepresenting eligibility information.
- Presenting an invalid prescription or physician order.
- Misusing a Molina Healthcare Member ID Card (or letting someone else use it).

After Your first 24 months of coverage, Molina Healthcare may not terminate Your coverage due to any intentional omissions, misrepresentations, or inaccuracies in Your application form.

If Molina Healthcare terminates Your membership for cause, You may not be allowed to enroll with Us in the future. We may also report criminal fraud and other illegal acts to the appropriate authorities for prosecution.

Discontinuation: If Molina Healthcare ceases to provide or arrange for the provision of health benefits for new or existing health care service plan contracts, in which case Molina Healthcare will provide You with written notice at least one-hundred-eighty (180) calendar days prior to discontinuation of those contracts.

Withdrawal of Product: Molina Healthcare withdraws this product from the market, in which case Molina Healthcare will provide You with written notice at least ninety (90) calendar days before the termination date.

Nonpayment of Premiums: If You do not pay required Premiums by the due date, Molina Healthcare may terminate Your coverage as further described below.

Your coverage under certain Benefits and Coverage will terminate if Your eligibility for such benefits end. For instance, a Member who attains the age of 19 will no longer be eligible for Pediatric Vision Services covered under this Agreement and, as a result, such Member's coverage under those specific Benefits and Coverage will terminate on his or her 19th birthday, without affecting the remainder of this EOC.

PREMIUM PAYMENTS AND TERMINATION FOR NON-PAYMENT

Premium Notices/Termination for Non-Payment of Premiums.
Your Premium payment obligations are as follows:

- Your Premium payment for the upcoming coverage month is due no later than the date stated on Your Premium bill. . This is the "**Due Date**". Molina Healthcare will send You a bill in advance of the Due Date for the upcoming coverage month. If Covered CaliforniaorMolina Healthcare does not receive the full Premium payment due on or before the Due Date, Molina Healthcare will send a notice of cancellation for nonpayment of Premiums and grace period, or, if You are receiving advanced payment of tax credit, a notice of suspension of coverage to the Subscriber's address of record.
- If You do not receive advance payment of the premium tax credit, Molina Healthcare will give You a thirty (30) calendar-day "grace period" Before cancelling or not renewing your coverage due to failure to pay Your Premium. Molina Healthcare will continue to provide coverage pursuant to the terms of this Agreement, including paying for Covered Services received during the thirty (30) calendar-day grace period. During the grace period, You can avoid cancellation or nonrenewal by paying the Premium You owe to Covered California or Molina Healthcare If You do not pay the Premium by the end of the grace period, this Agreement will be cancelled at the end of the grace period. You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period.
- If You receive advance payment of the premium tax credit, Molina Healthcare will give You a three-month "grace period" before cancelling or not renewing Your coverage due to failure to pay Your Premium. Molina Healthcare will pay for Covered Services received during the first month of the three-month grace period. If you do not pay the Premium by the end of the first month of the three-month grace period, Your coverage under this plan will be suspended and Molina Healthcare will not pay for Covered Services after the first month of the grace period until We receive the delinquent Premiums. If all Premiums due and owing are not received by the end of the three-month grace period, this Agreement will be cancelled effective the last day of the first month of the grace period You will still be responsible for any unpaid Premiums You owe Molina Healthcare for the grace period. Termination or nonrenewal of this Agreement for non-payment will be effective **as** of **11:59 p.m.:**
    - The last day of the thirty (30) calendar-day grace period if You do not receive advance payment of the premium tax credit; or,
    - The last day of the first month of the grace period if You receive advance payment of the premium tax credit

Termination Notice
Upon termination of this Agreement, Molina Healthcare will mail a Termination Notice to the Subscriber's address of record specifying the date and time when the membership ended.

If You claim that We ended the Member's right to receive Covered Services because of the Member's health status or requirements for health care services, You may request a review. To request a review call the Department of Managed Health Care by calling toll-free at 1 (800) 400-0815.

What are My Rights and Responsibilities as a Molina Healthcare Member?
These rights and responsibilities are posted on the Molina Healthcare web site: www.molinahealthcare.com/marketplace.

YOUR RIGHTS

You have the right to:
Be treated with respect and recognition of Your dignity by everyone who works with Molina Healthcare. Get information about Molina Healthcare, Our providers, Our doctors, Our services and Members' rights and responsibilities. Choose Your "main" doctor from Molina Healthcare's list of Participating Providers (This doctor is called Your Primary Care Doctor or Personal Doctor).

- Be informed about Your health. If You have an illness, You have the right to be told about all treatment options regardless of cost or benefit coverage. You have the right to have all Your questions about Your health answered.
- Help make decisions about Your health care. You have the right to refuse medical treatment.
- You have a right to Privacy. We keep Your medical records private.*
- See Your medical record. You also have the right to get a copy of and correct Your medical record where legally allowed.*
- Complain about Molina Healthcare or Your care. You can call, fax, e-mail, or write to Molina Healthcare's Customer Support Center.
- Appeal Molina Healthcare's decisions. You have the right to have someone speak for You during Your grievance.
- Disenroll from Molina Healthcare (leave the Molina Healthcare health plan).
- Ask for a second opinion about Your health condition.
- Ask for someone outside Molina Healthcare to look into therapies that are Experimental or Investigational.
- Decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get interpreter services on a 24-hour basis at no cost to help You talk with Your doctor or us if You prefer to speak a language other than English.
- Not be asked to bring a minor, friend, or family member with You to act as Your interpreter.
- Get information about Molina Healthcare, Your providers, or Your health in the language You prefer.
- Ask for and get materials in other formats such as, larger size print, audio and Braille upon request and in a timely fashion appropriate for the format being requested and in accordance with state laws.
- Receive instructions on how You can view online, or request a copy of, Molina Healthcare's non-proprietary clinical and administrative policies and procedures.
- Get a copy of Molina Healthcare's list of approved drugs (Drug Formulary) on request.
- Submit a grievance if You do not get Medically Necessary medications after an Emergency visit at one of Molina Healthcare's contracted hospitals.
- Not to be treated poorly by Molina Healthcare or Your doctors for acting on any of these rights.
- Make recommendations regarding Molina Healthcare's Member rights and responsibilities policies.
- Be free from controls or isolation used to pressure, punish, or seek revenge.
- File a grievance or complaint if You believe Your linguistic needs were not met by Molina Healthcare.

*Subject to State and Federal laws

Your Responsibilities
You have the responsibility to:

- Learn and ask questions about Your health benefits. If You have a question about Your benefits, call Molina toll-free at 1 (888) 858-2150.
- Give to Your doctor, provider, or Molina Healthcare information that is needed to care for You.
- Be active in decisions about Your health care.
- Follow the care plans for You that You have agreed upon with Your doctor(s).
- Build and keep a strong patient-doctor relationship. Cooperate with Your doctor and staff. Keep appointments and be on time. If You are going to be late or cannot keep Your appointment, call Your doctor's office.
- Give Your Molina Healthcare card when getting medical care. Do not give Your card to others. Let Molina Healthcare know about any fraud or wrong doing.
- Understand Your health problems and participate in developing mutually agreed-upon treatment goals, as You are able.

Be Active In Your Health Care

- Plan Ahead
- Schedule Your appointments at a good time for You
- Ask for Your appointment at a time when the office is least busy if You are worried about waiting too long
- Keep a list of questions You want to ask Your doctor
- Refill Your prescription before You run out of medicine

Make the Most of Doctor Visits

- Ask Your doctor questions
- Ask about possible side effects of any medication prescribed
- Tell Your doctor if You are drinking any teas or taking herbs. Also tell Your doctor about any vitamins or over–the-counter medications You are using

Visiting Your Doctor When You are Sick

- Try to give Your doctor as much information as You can.
- Are You getting worse or are Your symptoms staying about the same?
- Have You taken anything?

If You would like more information, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-2150, Monday through Friday, between 8:00 a.m. and 6:00 p.m.

MOLINA HEALTHCARE SERVICES

Molina Healthcare is Always Improving Services
Molina Healthcare makes every effort to improve the quality of health care services provided to You. Molina Healthcare's formal process to make this happen is called the "Quality Improvement Process". Molina Healthcare does many studies through the year. If we find areas for improvement, we take steps that will result in higher quality care and service.

If You would like to learn more about what we are doing to improve, please call Molina Healthcare toll-free at 1 (888) 858-2150 for more information.

Member Participation Committee
We want to hear what You think about Molina Healthcare. Molina Healthcare has formed the Member Participation Committee to hear Your concerns.

The Committee is a group of people just like You that meets once every three (3) months and tells Us how to improve. The Committee can review health plan information and make suggestions to Molina Healthcare's Board of Directors. If You want to join the Member Participation Committee, please call Molina Healthcare toll-free at 1 (888) 858-2150, Monday through Friday, 8:00 a.m. to 6:00 p.m. If You are deaf or hard of hearing, dial 711 for the Telecommunications Service. Join Our Member Participation Committee today!

Your Healthcare Privacy
Your privacy is important to Us. We respect and protect Your privacy. Please read Our Notice of Privacy Practices, at the front of this EOC.

New Technology
Molina Healthcare is always looking for ways to take better care of Our Members. That is why Molina Healthcare has a process in place that looks at new medical technology, drugs, and devices for possible added benefits.

Our Medical Directors find new medical procedures, treatment, drugs, and devices when they become available. They present research information to the Utilization Management Committee where physicians review the technology. Then they suggest whether it can be added as a new treatment for Molina Healthcare Members.

For more information on new technology, please call Molina Healthcare's Customer Support Center.

What Do I Have to Pay For?
Please refer to the "Molina Healthcare of California Benefits and Coverage Guide" at the front of this EOC for Your Cost Sharing responsibilities for Covered Services.

Note that You may be liable to pay for the full price of medical services when:

- You ask for and get medical services that are not covered.
- Except in the case of Emergency or out of area Urgent Care Services, You ask for and get health care services from a doctor or hospital that is not a Participating Provider with Molina Healthcare without getting an approval from Your PCP or Molina Healthcare

If Molina Healthcare fails to pay a Participating Provider for giving You Covered Services, You are not responsible for paying the provider for any amounts owed by Us. This is not true for providers who are not contracted with Molina Healthcare. For information on how to file a grievance if You receive a bill, please see below.

What if I have paid a medical bill or prescription?
(Reimbursement Provisions)
With the exception of any required Cost Sharing amounts (such as a Deductible, Copayment or Coinsurance), if You have paid for a Covered Service or prescription that was approved or does not require approval, Molina Healthcare will pay You back. You will need to mail or fax Us a copy of the bill from the doctor, hospital, or pharmacy and a copy of Your receipt. If the bill is for a prescription, You will need to include a copy of the prescription label. Mail this information to Molina Healthcare's Customer Support Center. The address is on page 1 of this EOC.

After we receive Your letter, we will respond to You within 30 days. If Your claim is accepted, we will mail You a check. If not, we will send You a letter telling You why. If You do not agree with this, You may appeal by calling Molina Healthcare toll-free at 1(888) 295-7651, Monday through Friday, 8:00 a.m. to 5:00 p.m. MT.

How Does Molina Healthcare Pay for My Care?
Molina Healthcare contracts with providers in many ways. Some Molina Healthcare Participating Providers are paid a flat amount for each month that You are assigned to their care, whether You see the provider or not. There are also some providers who are paid on a fee-for-service basis. This means that they are paid for each procedure they perform. Some providers may be offered incentives for giving quality preventive care. Molina Healthcare does not provide financial incentives for utilization management decisions that could result in Prior Authorization denials or under-utilization. For more information about how providers are paid, please call Molina Healthcare's Customer Support Center toll-free at 1 (888) 858-2150, Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also call Your provider's office or Your provider's medical group for this information.

Do You speak a Language other than English?
Many people do not speak English or are not comfortable speaking English. Please tell Your doctor's office or call Molina Healthcare if You prefer to speak a language other than English. Molina Healthcare can help You find a doctor that speaks Your language or have an interpreter help You.

Molina Healthcare offers telephonic interpreter services to help You with:

Making an appointment
Talking with Your doctor or nurse
Getting Emergency care in a timely manner
Filing a complaint or grievance
Getting health education management services
Getting information from the pharmacist about how to take Your medicine (drugs)

Tell Your doctor or anyone who works in his or her office if You need an interpreter. You may also ask for any of the documents that Molina Healthcare sends You in Your preferred written language. Members who need information in a language other than English or an accessible format (i.e. Braille, large print, audio) can call Molina Healthcare's Customer Support Center at 1 (888) 858-2150.

Cultural and Linguistic Services
Molina Healthcare can help You talk with Your doctor about Your cultural needs. We can help You find doctors who understand Your cultural background, social support services and help with language needs. Please call Molina Healthcare's Customer Support Center at 1 (866) 858-2150.

COMPLAINTS AND APPEALS

What if I Have a Complaint?
If You have a problem with any Molina Healthcare services including Pediatric Dental Services, We want to help fix it. You can call any of the following toll-free for help:

- Call Molina Healthcare toll-free at 1 (888) 858-2150, Monday through Friday, 8:00 a.m. - 6:00 p.m.. Deaf or hard of hearing Members may contact us by calling the California Relay Service at 711 if You are deaf or hard of hearing.

- You may also send us Your problem or complaint in writing by mail or filing online at Our website. Our address is:

  Molina Healthcare
  Grievance and Appeals Unit
  200 Oceangate, Suite 100
  Long Beach, California 90802
  www.molinahealthcare.com

- Call the California State Department of Managed Health Care (DHMC) toll-free at 1 (888) HMO-2219 (1-888-466-2219).

Molina Healthcare recognizes the fact that Members may not always be satisfied with the care and services provided by Our contracted doctors, hospitals and other providers. We want to know about Your problems and complaints. You may file a grievance (also called a complaint) in person, in writing, or by telephone as described above.

We will send You a letter acknowledging receipt of Your grievance within five (5) calendar days and will then issue a formal response within thirty (30) calendar days of the date of Your initial contact with us. All levels of grievances will be resolved within thirty (30) calendar days.

If You are not satisfied with Our response to Your grievance You may be able to file an appeal with Molina Healthcare if it is received and can be processed within thirty (30) calendar days of the initial receipt of the grievance. We will send You a letter acknowledging receipt of Your appeal within five (5) calendar days. All levels of Molina Healthcare's grievances and appeal procedures will be completed within thirty (30) calendar days.

You must file Your grievance within one hundred eighty (180) calendar days from the day the incident or action occurred which caused You to be unhappy.

Expedited Review
If Your grievance involves an imminent and serious threat to Your health, Molina Healthcare will quickly review Your grievance. Examples of imminent and serious threats include, but are not limited to, severe pain, potential loss of life, limb, or major bodily function. You will be immediately informed of Your right to contact the Department of Managed Health Care. Molina Healthcare will issue a formal response no later than three (3) calendar days after Your initial contact with us. You may also contact the Department of Managed Health Care immediately and are not required to participate in Molina Healthcare's grievance process.

Department of Managed Health Care Assistance
The California Department of Managed Health Care is responsible for regulating health care services plans. If You have a grievance against Your health plan, You should first telephone Your health plan toll-free at 1-888-665-4621, and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than thirty (30) days, You may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll free telephone number (1-888-HMO-2219) 1-888-466-2219 and a toll-free TTD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet website http:/www.hmohelp.ca.gov has complaint forms, IMR applications forms, and instructions online.

Independent Medical Review
You may request an independent medical review ("**IMR**") of a Disputed Healthcare Service from the Department of Managed Health Care ("**DMHC**") if You believe that healthcare services have been improperly denied, modified, or delayed by Molina Healthcare or one of its Participating Providers. A "**Disputed Healthcare Service**" is any healthcare service eligible for coverage and payment (also called Covered Services) that has been denied, modified, or delayed by Molina Healthcare or one of its Participating Providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no application or processing fees of any kind for IMR. You have the right to give information in support of the request for an IMR. Molina Healthcare will give You an IMR application form with any disposition letter that denies, modifies, or delays healthcare services. A decision not to take part in the IMR process may cause You to lose any statutory right to take legal action against Molina Healthcare regarding the disputed health care service.

Eligibility for IMR: Your application for an IMR will be reviewed by the DMHC to confirm that:
1. Either:
   A. Your provider has recommended a healthcare service as Medically Necessary, or
   B. You have received Urgent Care or Emergency Services that a provider determined was Medically Necessary, or
   C. You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which You seek medical review;

2. The Disputed Healthcare Service has been denied, modified, or delayed by Molina Healthcare or one of its Participating Providers, based in whole or in part on a decision that the healthcare service is not Medically Necessary: and

3. You have filed a grievance with Molina Healthcare or its Participating Provider and the disputed decision is upheld or the grievance remains unresolved after thirty (30) calendar days. You are not required to wait for a response from Molina Healthcare for more than thirty (30) calendar days.

   If Your grievance requires **Expedited Review** You may bring it immediately to the DMHC's attention. You are not required to wait for response from Molina Healthcare for more than

three (3) calendar days. The DMHC may waive the requirement that You follow Molina Healthcare's grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical Specialist Physician who will make an independent determination of whether or not the care is Medically Necessary. You will get a copy of the assessment made in Your case. If the IMR determines the service is Medically Necessary, Molina Healthcare will provide the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) calendar days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) calendar days.

For more information regarding the IMR process, or to request an application form, please call Molina Healthcare toll-free at 1 (888) 858-2150. If You are deaf or hard of hearing, call the California Relay Service at 711.

INDEPENDENT MEDICAL REVIEW FOR DENIALS OF EXPERIMENTAL/INVESTIGATIONAL THERAPIES

You may also be entitled to an Independent Medical Review of Our decision to deny coverage for treatment We have determined to be Experimental or Investigational.

- The treatment must be for a life-threatening or seriously debilitating condition.

- We will notify You in writing of the opportunity to request an Independent Medical Review of a decision denying an Experimental/ Investigational therapy within five (5) business days of the decision to deny coverage.

- You are not required to participate in Molina Healthcare's grievance process prior to seeking an Independent Medical Review of Our decision to deny coverage of an Experimental/ Investigational therapy.

- The Independent Medical Review will be completed within thirty (30) calendar days of the Department of Managed Health Care's receipt of Your application and supporting documentation. If Your doctor determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) calendar days of the completed request for an expedited review.

BINDING ARBITRATION: AGREEMENT TO RESOLVE ALL DISPUTES, INCLUDING FUTURE MALPRACTICE CLAIM BY BINDING ARBITRATION

Important Information about Your Rights

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this product, which may include but are not limited to claims of malpractice (e.g., in the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the health care provider) or claims that the medical services rendered under the product were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, between Member (including any heirs, successors or assigns of the Member) and Molina Healthcare, or any of its parents, subsidiaries, affiliates, successors, or assigns shall be submitted to binding arbitration in accordance with applicable state and federal laws, including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, California Code of Civil Procedure sections 1280 *et seq.* and the Affordable Care Act. Any such dispute will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

Member and Molina Healthcare agree that, by entering into the agreement enrolling Member in this product, Member and Molina Healthcare are each waiving the right to a trial by jury or to participate in a class action. Member and Molina Healthcare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of final and binding arbitration in accordance with the Comprehensive Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) calendar days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the JAMS Comprehensive Rules and Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery

may be taken in such arbitration in accordance with the California Code of Civil Procedure sections 1280-1294.2. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a California state law court including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

The parties shall divide equally the costs and expenses of JAMS and the arbitrator. In cases of extreme hardship, Molina Healthcare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The hardship application shall be made in a manner and with the information and any documentation as required by JAMS. JAMS (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

OTHER

MISCELLANEOUS PROVISIONS

Acts Beyond Molina Healthcare's Control
If circumstances beyond the reasonable control of Molina Healthcare, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of any facilities, personnel, or Participating Providers, then Molina Healthcare and the Participating Provider shall provide or attempt to provide Benefits and Coverage insofar as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina Healthcare nor any Participating Provider shall have any liability or obligation for delay or failure to provide Benefits and Coverage if such delay or failure is the result of any of the circumstances described above.

Waiver
Molina Healthcare's failure to enforce any provision of this Agreement shall not be construed as a waiver of that provision or any other provision of this Agreement, or impair Molina Healthcare's right to require Your performance of any provision of this Agreement.

Non-Discrimination
Molina Healthcare does not discriminate in hiring staff or providing medical care based on pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation.

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1(888) 295-7651.

Organ or Tissue Donation
The State's Legislature has asked Molina Healthcare to tell You that You can become an organ or tissue donor. Medical advancements in organ transplant technology have helped many patients. However, the number of organs available is much smaller than the number of patients in need of an organ transplant. You may choose to be an organ tissue donor by contacting the Department of Motor Vehicles to obtain an organ donation card.
Assignment
You may not assign this Agreement or any of the rights, interests, claims for money due, benefits, claims, or obligations hereunder without Molina's prior written consent (which consent may be refused in Molina's discretion).

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with California law and any provision that is required to be in this Agreement by state or federal law shall bind Molina Healthcare and Members whether or not set forth in this Agreement.

Invalidity
If any provision of this Agreement is held illegal, invalid or unenforceable in a judicial proceeding or binding arbitration, such provision shall be severed and shall be inoperative, and the remainder of this Agreement shall remain operative and in full force and effect.
Notices
Any notices required by Molina Healthcare under this Agreement will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying Us of any change in address.

HEALTH EDUCATION AND HEALTH MANAGEMENT LEVEL 1 PROGRAMS

The tools and services described here are educational support for Our Members. We may change them at any time as necessary to meet the needs of Our Members.

Health Management
Molina Healthcare offers programs to help keep You and Your family healthy. You may ask for booklets on topics such as:

- Asthma management
- Diabetes management
- High blood pressure
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management

You can also enroll in any of the programs above by calling the Molina Healthcare Health Management Department at 1-866-472-9483, between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Motherhood Matters®
A Prenatal Care Program for Pregnant Women

Pregnancy is an important time in Your life. It can be even more important for Your baby. What You do during Your pregnancy can affect the health and well-being of Your baby – even after birth.

Motherhood Matters® is a program for pregnant women. This program will help women get the education and services they need for a healthy pregnancy. You will be mailed a pregnancy book that You can use as a reference throughout Your pregnancy.
You will be able to talk with Our caring staff about any questions You may have during Your pregnancy. They will teach You what You need to do. If any problems are found, a nurse will work closely with You and Your doctor to help You. Being a part of this program and following the guidelines will help You have a healthy pregnancy and a healthy baby.

Your Baby's Good Health Begins When You Are Pregnant
You Learn:

- Why visits to Your doctor are so important.
- How You can feel better during Your pregnancy.
- What foods are best to eat?
- What kinds of things to avoid.
- Why You should stay in touch with Molina Healthcare's staff.
- When You need to call the doctor right away.

Other benefits include

- Health Education materials including a pregnancy book. Referrals – To community resources available for pregnant women.

To find out more about the Motherhood Matters® program, call the Molina Health Management Department at 1-866-472-9483, between 8:00 a.m. and 6:00 p.m., Monday through Friday.

HEALTH MANAGEMENT LEVEL 1 PROGRAMS

Molina's Health Management Level 1 Programs Department is committed to helping You stay well. Find out if You are eligible to sign up for one of Our programs.

Call toll-free:

Molina Health Management Department at
1-866-472-9483,
between 8:00 a.m. and 6:00 p.m.,
Monday through Friday.

Ask about other services We provide or request information to be mailed to You.

Smoking Cessation Program
This program offers smoking cessation services to all smokers interested in quitting the habit. The program is done over the telephone. You will also be mailed educational materials to help You stop the habit. A smoking cessation counselor will call You to offer support.

Weight Control Program
This program is for Members who need help controlling their weight.

The weight control program is provided for Members 17 years and older. You will learn about healthy eating and exercise. This program is for Members who are ready to commit to losing weight. Once You have understood and agreed to the program participation criteria, You can enroll in the program.

YOUR HEALTHCARE QUICK REFERENCE GUIDE

Department/Program	Type of help needed	Number to call/ Contact information
Molina Healthcare Customer Support Center Department	If You have a problem with any of Molina Healthcare's services, we want to help fix it. You can call Our Customer Support Center for help or to file a grievance or complaint Monday through Friday from 8:00am to 6:00pm. When in doubt, call Us first.	**Customer Support Center Toll Free:** 1 (888) 858-2150 **TTY line for the deaf or hard of hearing:** dial 711 for the Telecommunications Service
Health Management	To request information on wellness including, but not limited to, nutrition, smoking cessation, weight management, stress management, child safety, asthma, and diabetes, Cardiovascular Disease (CVD), or Chronic Obstructive Pulmonary Disease (COPD).	1 (866) 472-9483 8:30 a.m. and 5:30 p.m. Monday through Friday(PT)
Health Management Level 1 Programs	To request information on smoking cessation and weight management.	1 (866) 472-9483 9:30 a.m. and 6:30 p.m. (PT) Monday through Friday
Molina Healthcare Bridge2 Access Connections Program	The Bridge2Access Connections Program can help You get the answer to a question or concern that may not have received from the Customer Support Center.	1 (877) 665-4627
Motherhood Matters®	Molina Healthcare offers a special program called Motherhood Matters® to Our pregnant Members. This program provides important information about diet, exercise and other topics related to Your pregnancy.	1 (877) 665-4628
Nurse Advice Line 24-Hour, 7 days a week	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses.	1 (888) 275-8750 or, for Spanish, at 1 (866) 648-3537
Secretary of the U.S. Department of Health and Human Services Office for Civil Rights	If You believe that we have not protected Your privacy and wish to complain, You may call to file a complaint (or grievance).	(415) 437-8310 TDD for deaf or hard of hearing: (415) 437-8311 FAX: (415) 437-8329
Medicare	Medicare is health insurance offered by the federal government to most people who are 65 and older. Medicare helps pay for healthcare, but does not cover all medical expenses.	1 (800) MEDICARE TTY for deaf or hard of hearing: 1 (877) 486-2048 www.Medicare.gov
Department of Managed Health Care (DMHC)	The California Department of Managed Health Care is responsible for regulating health care services plans. If You have a grievance against Molina Healthcare, You should first call Molina Healthcare toll-free at 1-888-858-2150, and use Molina Healthcare's grievance process before contacting this department.	1 (800) 400-0815 **www.hmohelp.ca.gov** 1 (888) HMO-2219 (1-888-466-2219) or TDD: 1 (877) 688-9891.

ADDENDUM FOR 2016
PEDIATRIC DENTAL SERVICES

To be provided by California Dental Network, Inc.

200 Oceangate, Suite 100
Long Beach, CA 90802

DEFINITIONS

"Emergency Service" means service required for immediate relief of severe pain or bleeding associated with dental problems and/or diagnosis and treatment of dental conditions which, if not treated right away, may lead to disability or death.

"Exclusion" means any service that is listed as not covered by CDN or the Provider.

"Limitation" means any service other than an Exclusion that restricts Coverage under this plan.

"Dental Provider" refers to those dentists, who have contracted with CDN, and includes any hygienists or assistants that act under the supervision of the dentist, to provide services to Members.

"Dental Specialist" means a dentist who is responsible for the dental care of a Member in one field of dentistry, such as endodontics, periodontics, pedodontics, oral surgery, or orthodontics.

"Participating Dental Provider" means a dentist who has a contract with CDN to treat our insured members.

"Primary Dentist" means the main dentist who the member has elected or has been assigned to for their dental treatment and is a participating dental provider.

How do I use my benefits?
In addition to your Molina Healthcare of California EOC you will receive a letter from California Dental Network (CDN) with the telephone number and address of Your dental office.

A complete list of covered services and copayments is included at the end of this Addendum. Services excluded from Your Coverage are found in the section titled Benefits. Exclusions and Limitations. Please read this section carefully. Dental services by an out-of-network dentist or specialist are not covered. Under certain emergency situations services by a non-participating general dentist may be covered.

HOW DO I CHANGE MY DENTAL PROVIDER?
THE FOLLOWING INFORMATION TELLS YOU THE GROUPS OF PROVIDERS WHO CAN PROVIDE YOU WITH DENTAL CARE.

You may select any CDN Participating Dental Provider for Your dental care. You can change Your Primary Dentist at any time. Please contact Dental Customer Support toll-free at 1-855-230-5530 to change your Primary Dentist. Any request received by the 20th of the month is effective on the first day of the month following. Any request received after the 20th of the month is effective on the first day of the following calendar month. We may require up to 30 days to process a request.

Please contact Dental Customer Service for a copy of our policy on second opinions.

DENTAL PROVIDERS

CDN's participating dental offices are open during normal business hours and some offices are open on Saturday. Check your provider directory for more information on provider office hours and languages spoken at participating offices. If You are having difficulty locating a Participating Dental Provider in your area within the access standards of the plan, contact Dental Customer Support at 1-855-230-5530 to receive authorization for out of network services. You will be able to select a provider of your choice in the immediate area. Authorization will be given for exam and x-rays, all treatment must be submitted for approval.

How do I get Emergency Services?
Emergency dental services are covered 24 hours a day, seven days a week, to all Members. Emergency Service means service required for immediate relief of severe pain or bleeding associated with dental problems and/or diagnosis and treatment of dental conditions that, if not treated right away, may lead to disability or death. The covered benefits must be to relieve severe pain or bleeding only. Please contact Your Dental Provider for emergency dental care. If Your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-855-230-5530.

What do I do if I am out of the area?
You are covered for emergency dental services if you are more than 50 miles from Your Dental Provider.

Member claims must be filed within 60 days and we will reimburse Members within 30 days for any emergency expenses. You are required to submit a detailed statement from the treating dentist with a list of all the services provided. A non-covered parent of a covered child may submit a claim for an out-of-area emergency without the approval of the covered parent, in that case the non-covered parent will be reimbursed. Submit all claims to CDN at this address:

California Dental Network, Inc.
12121 North Corporate Parkway
Mequon, WI 53092
To see a Specialist

If Your Primary Dentist decides that You need the services of a specialist, they will request Prior Authorization for a referral to a CDN Specialist. CDN will send You a letter of treatment authorization, including the name, address, and phone number of Your assigned CDN specialist. Routine Prior Authorization requests will be processed within five (5) business days from receipt of all information reasonably necessary and requested by CDN to make the determination. If an emergency referral is required, Your Primary Dentist will contact CDN and prompt arrangements will be made for specialty treatment. Emergency referrals are processed within seventy-two (72) hours from receipt of all information reasonably necessary and requested by CDN to make the determination. Your Primary Dentist will be informed of CDN's decision within 24 hours of the determination. Both the general provider and the patient will be notified in writing of approval or denial. If You have questions about how a certain service is approved, call CDN toll-free at 1-855-230-5530. If You are deaf or hard of hearing, dial 711 for the California Relay Service. We will be happy to send You a general explanation of how that type of decision is made or send You a general explanation of the overall approval process if You request it.

If you request services from any specialist without prior written approval, you will be responsible for payment.

COMPLAINTS AND APPEALS

All dental complaints and appeals will be handled according to Molina's complaints and appeals process as outlined in this EOC.

BENEFITS, EXCLUSIONS, AND LIMITATIONS

Pediatric Dental Essential Health Benefits are set forth in the attached list of covered procedures and are subject to the applicable member cost (copayment) in the list, when provided by a CDN Participating Dental Provider and subject to the Exclusions and Limitations contained herein. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable.

CDN Pediatric Dental Essential Health Benefits Exclusions and Limits
Covered pediatric dental essential health benefits are limited to the least costly or appropriate option. Members will need to pay for all charges over the least costly covered dental benefit. Coverage of pediatric dental essential health benefits is limited to dependent children under the age of 19.

Benefits and Limits for Diagnostic and Preventive Services:

- Two oral evaluations are covered per calendar year. (D0120, D0145, D0150)
- One comprehensive evaluation is covered per calendar year. (D0150)
- One limited oral evaluation; problem-focused is covered per calendar year. (D0140)
- On series of four bitewing per six months is covered. Extra films are covered on an emergency or case-by-case basis.
- One full mouth x-rays per 36 months is covered.
- One panoramic x-rays per 36 months is covered.
- Two routine cleanings per calendar year are covered. (D1110, D1120)
- Two topical fluoride applications per calendar year are covered. (D1206, D1208) More cleanings and/or fluoride require Plan approval.
- One sealant per tooth every 36 months is covered. Sealants are limited to permanent molars (D1351, D1352)
- One space maintainers per quadrant per member ages 0-17 is covered. (D1510, D1515, D1520, D1525) Recementation is limited to once per provider, per quadrant per member ages 0-17. (D1550)

Benefits and Limits for Restorative Services:

- One silver and one tooth colored filling per tooth, per surface per calendar year is covered for baby teeth. One silver and one tooth colored filling per tooth, per surface per 36 months is covered for permanent teeth. (D2140-D2394)
- Repair or replacement by the same dentist is part of in the initial service. A separate fee cannot be charged to the Member.
- The covered restorations include all related services.
- One premade crown per tooth per calendar year is covered for baby teeth and one per tooth per 36 months is covered for permanent teeth. (D2929-D2933)
- One lab made crown per tooth per 5 years is covered for members ages 13 or older and Plan approves. (D2710-D2792)
- Core buildups are covered only when this is needed to make the tooth stronger to hold the crown. (D2950)
- Replacement of restorations is limited to once per 36 months ago. There must be information sent to show the current item is not and cannot be repaired.
- Crowns and posts and cores are covered only when needed due to cavities or tooth fracture. If the tooth can be adequately restored with a filling, the filling will be covered.
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- Recementation is covered once per 6 months. Recementation done within 12 months of placement by the same dentist is included at no added cost to the Member.
- Adjustments to crowns and bridges during the first 6 months after insertion are included at no added fee to the member.

Benefits and Limits for Endodontic Services:

- Pulpotomy canal therapy is covered for permanent teeth. (D3310, D3320, D3330)
- Pulpotomy is covered when done as a final step in root canal therapy. It is covered for baby teeth only. Pulpotomies done on permanent teeth are part of root canal therapy and are not paid separate. There may be exceptions when specific information is provided and root canal therapy is not done on the same tooth. (D3220)
- Pulpal therapy is covered for baby teeth. (D3230, D3240)
- The service date for endodontic therapy is the date the tooth is sealed.
- Retreatment of root canal therapy is not covered for the original treating provider within 12 months of initial treatment. (D3346, D3347, D3348)

Benefits and Limits for Periodontal Services:

- Periodontal procedures are covered for members age 13 or older. Up to 5 quadrants per calendar year are covered. More services require Plan approval.
- Plan approval is required for all periodontal services except D4290 and D4910.
- Scaling and root planing is covered once per 24 months per quadrant. (D4341, D4342)
- Gingivectomy or gingivoplasty and osseous surgery are covered once per 36 months per Plan approval is required for all periodontal services except D4290 and D4910.
- Scaling and root planing is covered once per 24 months per quadrant. (D4341, D4342)
- Gingivectomy or gingivoplasty and osseous surgery are covered once per 36 months per quadrant. (D4210, D4211, D4260, D4261)
- An oral evaluation done with periodontal maintenance is covered as a separate procedure. (D4910)

Benefits and Limits for Oral Surgery Services:

- Simple and surgical extractions of teeth are covered. Surgical extractions require Plan approval. (D7211 – D7250)
- Charges for services and supplies related to surgery are included in the fee for the surgery.
- Routine post-op care is included with the fee for the surgery services is included with the fee for the surgery
- Extractions are limited to the tooth position seen in the X-rays. They require Plan approval. If the degree of impaction is less than reported, coverage is based on the benefit for the lesser level of removal. (D7111-D7250)
- Incision and drainage of an abscess is a covered service. (D7510, D7511, D7520, D7521)
- Biopsies require a pathology report. (D7285, D7286) The removal of lesions is covered when Plan approves. (D7410-D7415, D7440, D7441, D7450, D7451, D7460, D7461, D7465)
- Extensive surgery of the jaw requires Plan approval.

Benefits and Limits for Prosthodontic Services:

- Plan approval is needed for removable dentures. Immediate dentures do not need Plan approval. (D5130, D5140)
- Temporary dentures used while a permanent denture is being made are not a covered service.
- Services done to prepare for a bridge or denture to replace missing teeth prior to Effective Date of Coverage are not covered.
- The date of service for crowns and fixed partial dentures is the placement date. The date of service for removable partial dentures is the insertion date.
- Recementation of crowns, bridges, and posts is covered once per 6 months. Recementation done within 12 months of placement by the same dentist is included at no added cost to the Member.
- Adjustments done within 6 months of the insertion of the denture are included at no added cost to the Member when made by the same dentist.
- Adjustments done to make a denture fit better are covered at no added cost to the Member within 6 months of the insertion of the denture.
- Adjustments done to make the denture fit better are covered once every 36 months.
- Dentures and overdentures made with precious metals are covered under the benefit for a regular denture. Additional services to prepare for an overdenture are not covered
- Removable and fixed dentures are covered once in 36 months. (D5110 - D5214and D6210 – D6792) Prior to replacement, information must be provided to show the existing denture is not working properly. The 36 month limit is measured by the actual date of the initial insertion versus the first day of the initial service month.
- Replacement of dentures that have been lost, stolen, or misplaced is not a covered service.

Policies, Limits, and Exclusions for Orthodontic Services - Medically Necessary:

- Services are limited to medically necessary orthodontics. Services must be done by a Participating Dental Provider with Prior Authorization.
- Orthodontic procedures are covered when Member has a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions listed below.
    - Automatic conditions are:
    - Cleft palate deformity. If the cleft palate is not visible on the casts, a letter from a credentialed specialist shall be sent on their letterhead, with the prior authorization request.
    - A deep impinging overbite in which the lower front teeth are destroying the soft tissue of the palate;
    - A crossbite of individual front teeth cause destruction of soft tissue;

  - An overjet greater than 9 mm or reverse overjet greater than 3.5 mm; and
  - Severe traumatic deviation.
- General dentist referrals for initial consultation must include an HLD score sheet which is completed and signed by the general dentist. The score sheet must document the qualifying score and/or conditions.
- The score sheet must be sent by the contracted orthodontist to the Plan with the prior authorization request:
  - ADA 2006 or newer claim form with service code(s) requested;
  - Trimmed diagnostic study models with bite registration; or an OrthoCad equivalent;
  - Cephalometric or panoramic x-ray;
  - HLD score sheet, completed and signed by the Orthodontist; and
  - HLD score sheet, completed and signed by the Orthodontist; and
  - Treatment plan.
- Coverage for comprehensive orthodontic treatment procedures includes all appliances, adjustments, insertion, removal, and retainers. No added charges to the Member are permitted. (D8080)
- Only those cases with permanent teeth will be considered, unless the Member is age 13 or older and still has some baby teeth.
- Repair and replacement of an orthodontic appliance that has been damaged, lost, stolen, or misplaced is not a covered service.

Benefits and Limitations for General Services:

- General anesthesia and sedation are covered when done with a covered procedure(s) and Plan approves. This must be done by a dentist or individual licensed dentist and approved to give anesthesia in the state where the service is rendered. (D9220, D9221, D9230, D9241, D9242)
- Oral sedation is covered for Members up to age 7, the developmentally disabled or any age, and Members with medical conditions that need general anesthesia.
- Emergency treatment must involve a problem or symptom that happened suddenly and unexpectedly and requires immediate attention. (D9110)
- Consultations are covered only when done by a dentist other than the dentist doing the treatment. (D9310)
- After hours visits are covered only when the dentist must return to the office after regular business hours to treat the Member in an emergency. (D9440)
- Therapeutic drug injections are covered in unusual circumstances. A report must be sent to describe the situation. (D9610)

Exclusions:

Except as previously listed, the following services, supplies, or charges are **<u>not covered</u>**:

- Any dental service or treatment not specifically listed as a covered service.
- Services not ordered or done in the direct supervision of a dentist. Exceptions may be made in those areas where dental hygienists are permitted to practice without supervision by a dentist. Services submitted by a dentist for the same services performed on the same date for the same Member by another dentist.
- Services to treat any illness or bodily injury due to employment if benefits or compensation is available, in whole or in part, under the provision of any legislation of any governmental unit. This exclusion applies whether or not the member claims the benefits or compensation.
- Services later recovered in a lawsuit or in a compromise or settlement of any claim, except where prohibited by law.
- Services provided free of charge except where this exclusion is prohibited by law.
- Services the member would have no obligation to pay in the absence of this or any similar

coverage.

- Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
- Services done prior to the Member's effective coverage date.
- Services done after the termination date of the member's coverage unless otherwise indicated.
- Services not medically or dentally necessary, or which are not recommended or approved by the treating dentist. (These services may not billable to the Member by a Participating Dental Provider unless the dentist notifies the Member of prior to treatment and the Member chooses to receive the treatment. Participating Dental Providers should document this in their records.)
- Service not meeting accepted standards of dental practice.
- Any charges for missed appointments.
- Hospital costs or any added fees the dentist or hospital charges for treatment at the hospital (inpatient or outpatient).
- Charges for copies of Members' records, charts or x-rays, or any costs associated with forwarding/mailing copies of Members' records, charts, or x-rays.
- Services for dependent children age 19 and over.
- Treatment for relief of Myofascial Pain Dysfunction Syndrome (MFPS) or Temporomandibular Joint Dysfunction (TMJD).
- Adjunctive dental care as listed:
    a. Part of the treatment of a covered medical condition.
    b. Necessary to control the primary medical condition.
    c. Preparation for or as the result of dental trauma, which may be or is caused by treatment of an injury or disease.

DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records are confidential. This confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.
This information may also be made available to the Department of Managed Health Care, the Dental Board, and CDN's legal representatives or other agencies as required by law.
A Plan Member or the non-covered parent of a covered child may request access to or a copy of personal information and medical records. Written consent for release of patient information and records must be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to the request within 30 days after we receive it.

California Dental Network's confidentiality policy is available for review to all plan members upon request.

A Plan Member may request to have an addendum of 250 or fewer words added to his or her medical records, in compliance with state law. This request should be made directly to the provider who has custody of the records. If the provider denies Member the request to add an addendum, the Member should contact Dental Customer Support for assistance.

A STATEMENT OF OUR CONFIDENTIALITY POLICY IS AVAILABLE TO YOU UPON REQUEST.

GENERAL PROVISIONS

- CDN is subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 as amended and Subchapter 5.5 of Chapter 3 of Title 10 of the California Code of Regulations, and any provisions required to be in this Agreement by either of the above shall bind CDN whether or not provided in this Agreement. In the event that the Act or Regulations thereunder set forth any requirement that is not included herein or is contrary to this Agreement, it shall supersede the applicable provisions of this Agreement and shall be binding unto the parties hereto.
- Nothing contained herein shall preclude CDN from changing the location of any of its dental offices, as long as it retains a sufficient Provider network to provide dental services to Group.
- In the event any of CDN's Providers should terminate their relationship with CDN, breach their Provider Agreement with CDN, or be unable to render dental services hereunder, and Members would be adversely or materially affected, CDN will give effected Members written notice thereof.
- Upon termination of a Provider Contract, CDN shall be responsible to ensure completion of the covered services rendered by such Provider (other than for Copayments as defined in subdivision (g) of Section 1345 of the Act) to Members who retain eligibility under this Agreement or by operation of law under the care of such Provider at the time of such termination until the services being rendered to the Members by such Provider are completed, unless CDN makes reasonable and medically appropriate provisions for the assumption of such services by another Provider.
- If any provision of this Agreement is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Agreement, and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Agreement.

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS
Molina Bronze^{60} HMO

Pediatric Dental Essential Health Benefits apply to members up to the age of 19. Member copayments/cost shares paid for pediatric dental essential health benefits accrue toward the Annual Out-of-Pocket Maximum and deductible as applicable. Minimum coverage plan benefits are covered at 100% by the plan after the member meets the deductible and Annual Out-of-Pocket Maximum. Please refer to page 17 for information on Annual Out-of-Pocket Maximum. Members should keep receipts for all dental work to show out-of-pocket costs.

The following is a list of Covered Pediatric Dental Essential Health Benefits, along with your cost share, when performed by a CDN Participating Dental Provider and subject to the exclusions and limitations in this EOC:

Code	Description	Member Copayment

Diagnostic Services

All radiographs and all diagnostic images include reading and interpretation by any contracting provider. Contracted dentists may not charge a surcharge to interpret diagnostic images.

Code	Description	Member Copayment
	Office Visit, per visit	$0.00
D0120	Periodic oral evaluation	$0.00
D0140	limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation under age 3	$0.00
D0150	Comprehensive oral evaluation	$0.00
D0210	Intraoral, complete series of radiographic images	$0.00
D0220	Intraoral, periapical, first radiographic image	$0.00
D0230	Intraoral, periapical, each add'l radiographic image	$0.00
D0240	Intraoral, occlusal radiographic image	$0.00
D0270	Bitewing, single radiographic image	$0.00
D0272	Bitewings, 2 radiographic images	$0.00
D0273	Bitewings, 3 radiographic images	$0.00
D0274	Bitewings, 4 radiographic images	$0.00
D0277	Vertical bitewings - 7 to 8 radiographic images	$0.00
D0330	Panoramic radiographic image	$0.00
D0460	Pulp vitality tests	$0.00

Preventive Services

* - Procedures limited to twice in 12 consecutive months

D1110	Prophylaxis, adult *	$0.00
D1120	Prophylaxis, child *	$0.00
D1206	Topical application of fluoride varnish	$0.00
D1208	Topical application of fluoride	$0.00
D1310	Nutritional counseling for control of dental disease	$0.00
D1320	Tobacco counseling for the control and prevention of oral disease	$0.00
D1330	Oral hygiene instruction	$0.00
D1351	Sealant, per tooth	$0.00
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	$0.00
D1510	Space maintainer, fixed, unilateral	$0.00
D1515	Space maintainer, fixed, bilateral	$0.00
D1520	Space maintainer, removable, unilateral	$0.00
D1525	Space maintainer, removable, bilateral	$0.00
D1550	Re-cementation of space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00

Restorative Services

Includes all bases, liners, adhesives, bonding agents, desensitizing agents, removal of existing restorations.

D2140	Amalgam, 1 surface, primary or permanent	$25.00
D2150	Amalgam, 2 surfaces, primary or permanent	$29.00
D2160	Amalgam, 3 surfaces, primary or permanent	$35.00
D2161	Amalgam, 4 or more surfaces, primary or permanent	$42.00
D2330	Resin-based composite, 1 surface, anterior	$27.00
D2331	Resin-based composite, 2 surfaces, anterior	$31.00
D2332	Resin-based composite, 3 surfaces, anterior	$37.00
D2335	Resin-based composite, 4+ surfaces/incisal angle	$44.00
D2391	Resin-based composite, 1 surface, posterior	$32.00
D2392	Resin-based composite, 2 surfaces, posterior	$37.00

Restorative Services
Includes all bases, liners, adhesives, bonding agents, desensitizing agents, removal of existing restorations.

D2393	Resin-based composite, 3 surfaces, posterior	$46.00
D2394	Resin-based composite, 4+ surfaces/incisal, posterior	$56.00

Inlays/Onlays

Includes all bases, liners, adhesives, bonding agents, desensitizing agents, removal of existing restorations.

D2542	Onlay, metallic, 2 surfaces	$154.00
D2543	Onlay, metallic, 3 surfaces	$161.00
D2544	Onlay, metallic, 4 or more surfaces	$167.00

Crowns

Includes all bases, liners, adhesives, bonding agents, desensitizing agents, removal of existing restorations, and temporization.
Restorations with noble, high noble and full porcelain (noted with **) additional fee of up to $250 is the patient responsibility; this fee will not be applied to the patient OOP maximum.

D2710	Crown, resin-based composite (indirect)	$66.00
D2720	Crown, resin with high noble**	$162.00
D2721	Crown, resin with predominantly base metal	$152.00
D2722	Crown, resin with noble**	$155.00
D2740	Crown, porcelain/ceramic substrate	$300.00
D2750	Crown, porcelain fused to high noble**	$300.00
D2751	Crown, porcelain fused to predominantly base metal	$300.00
D2752	Crown, porcelain fused to noble**	$300.00
D2780	Crown, ¾ cast high noble**	$300.00
D2781	Crown, ¾ cast predominantly base metal	$300.00
D2782	Crown, ¾ cast noble**	$300.00
D2783	Crown, ¾ porcelain/ceramic substrate**	$300.00
D2790	Crown, full cast high noble**	$300.00
D2791	Crown, full cast predominantly base metal	$300.00
D2792	Crown, full cast noble**	$300.00
D2794	Crown - titanium	$300.00
D2910	Recement inlay, onlay, partial coverage restoration	$14.00
D2915	Recement cast or prefabricated post and core	$14.00
D2920	Recement crown	$14.00
D2930	Prefabricated stainless steel crown, primary tooth	$39.00
D2931	Prefabricated stainless steel crown, permanent tooth	$44.00
D2932	Prefabricated resin crown	$47.00
D2933	Prefabricated stainless steel crown w/ resin window	$54.00
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	$54.00
D2940	Protective restoration (temporary)	$15.00
D2949	Restorative foundation for an indirect restoration	$15.00
D2951	Pin retention, per tooth, in addition to restoration	$9.00
D2952	Post & core in addition to crown, indirect fabric.	$59.00
D2954	Prefabricated post & core in addition to crown	$47.00
D2955	Post removal	$0.00
D2970	Temporary crown (fractured tooth)	$24.00

D2971	Additional procedures to construct new crown under existing partial denture framework	$24.00
D2980	Crown repair, restorative material failure	$0.00

Endodontics (excluding final restorations)

Includes all irrigants, adhesives, and filling materials, removal of existing restorations, and post-treatment temporization.

D3110	Pulp cap – direct (excluding final restoration)	$15.00
D3120	Pulp cap - indirect (excluding final restoration)	$15.00
D3220	Therapeutic pulpotomy (excluding final restoration)	$31.00
D3221	Pulpal debridement, primary and permanent teeth	$35.00
D3222	Partial pulpotomy for apexogenesis, permanent tooth	$35.00
D3230	Pulpal therapy, anterior, primary tooth	$26.00
D3240	Pulpal therapy, posterior, primary tooth	$32.00
D3310	Endodontic therapy Anterior (excluding final restoration)	$103.00
D3320	Endodontic therapy Bicuspid (excluding final restoration)	$126.00
D3330	Endodontic therapy Molar (excluding final restoration)	$300.00
D3346	Retreatment of previous root canal – anterior	$137.00
D3347	Retreatment of previous root canal – bicuspid	$161.00
D3348	Retreatment of previous root canal – molar	$200.00
D3351	Apexification/recalcification/pulp reg. – initial visit	$59.00
D3352	Apexification/recalcification/pulp reg. – interim med.	$27.00
D3353	Apexification/recalcification – final visit	$82.00
D3410	Apicoectomy/periradicular surgery – anterior	$118.00
D3421	Apicoectomy/periradicular surgery – bicuspid	$131.00
D3425	Apicoectomy/periradicular surgery – molar	$148.00
D3426	Apicoectomy/periradicular surgery – each add 'l root	$50.00
D3430	Retrograde filling – per root	$37.00
D3450	Root Amputation – per root	$77.00

Periodontics

D4210	Gingivectomy/gingivoplasty, 4+ teeth per quadrant	$150.00
D4211	Gingivectomy/gingivoplasty, 1-3 teeth per quadrant	$75.00
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$150.00
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4260	Osseous surgery, 4+ teeth per quadrant	$233.00
D4261	Osseous surgery, 1-3 teeth per quadrant	$125.00
D4341	Periodontal scaling & root planing, 4+ teeth per quadrant	$35.00
D4342	Periodontal scaling & root planing, 1-3 teeth per quadrant	$20.00
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$23.00

Removable Prosthodontics

Except when noted, includes all lab costs and post-delivery adjustments for 6 months following delivery. Replaced once every 3 years from initial placement under Plan coverage & relined once every 24 months, as per limitations, exclusions, and guidelines.

D5110	Complete denture, maxillary	$220.00
D5120	Complete denture, mandibular	$220.00
D5130	Immediate denture - maxillary	$300.00
D5140	Immediate denture - mandibular	$300.00
D5211	Maxillary partial denture, resin base	$186.00
D5212	Mandibular partial denture, resin base	$216.00
D5213	Maxillary partial denture, cast metal/resin base	$243.00
D5214	Mandibular partial denture, cast metal/resin base	$243.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$243.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$243.00
D5410	Adjust complete denture, maxillary	$12.00

Removable Prosthodontics

Except when noted, includes all lab costs and post-delivery adjustments for 6 months following delivery. Replaced once every 3 years from initial placement under Plan coverage & relined once every 24 months, as per limitations, exclusions, and guidelines.

D5411	Adjust complete denture, mandibular	$12.00
D5421	Adjust partial denture, maxillary	$12.00
D5422	Adjust partial denture, mandibular	$12.00
D5510	Repair broken complete denture base	$24.00
D5520	Replace missing/broken teeth, complete denture	$20.00
D5610	Repair resin denture base	$26.00
D5620	Repair cast framework	$28.00
D5630	Repair or replace broken clasp	$34.00
D5640	Replace broken teeth, per tooth	$22.00
D5650	Add tooth to existing partial denture	$30.00
D5660	Add clasp to existing partial denture	$36.00
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$88.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$88.00
D5710	Rebase complete maxillary denture	$89.00
D5711	Rebase complete mandibular denture	$85.00
D5720	Rebase maxillary partial denture	$84.00
D5721	Rebase mandibular partial denture	$84.00
D5730	Reline complete maxillary denture, chairside	$50.00
D5731	Reline complete mandibular denture, chairside	$50.00
D5740	Reline maxillary partial denture, chairside	$46.00
D5741	Reline mandibular partial denture, chairside	$46.00
D5750	Reline complete maxillary denture, laboratory	$67.00
D5751	Reline complete mandibular denture, laboratory	$67.00
D5760	Reline maxillary partial denture, laboratory	$66.00
D5761	Reline mandibular partial denture, laboratory	$66.00
D5850	Tissue conditioning, maxillary	$21.00
D5851	Tissue conditioning, mandibular	$21.00

Fixed Prosthodontics

Includes all bases, liners, adhesives, bonding agents, desensitizing agents, removal of existing restorations, and temporization.
Restorations with noble, high noble and full porcelain (noted with **) additional fee of up to $250 is the patient responsibility; this fee will not be applied to the patient OOP maximum.

D6210	Pontic, cast high noble**	$300.00
D6211	Pontic, cast predominantly base metal	$300.00
D6212	Pontic, cast noble**	$300.00
D6214	Pontic - titanium	$300.00
D6240	Pontic, porcelain fused to high noble**	$300.00
D6241	Pontic, porcelain fused to predominantly base metal	$300.00
D6245	Pontic, porcelain/ceramic	$300.00
D6250	Pontic, resin with high noble**	$300.00
D6251	Pontic, resin with predominantly base metal	$131.00
D6252	Pontic, resin with noble**	$135.00
D6610	Onlay, cast high noble**	$123.00
D6611	Onlay, cast high noble**	$134.00
D6612	Onlay, cast predominantly base metal, two surfaces	$122.00
D6613	Onlay, cast base metal, 3 or more surfaces	$127.00
D6614	Onlay, cast noble**	$119.00
D6615	Onlay, cast noble**	$124.00
D6720	Crown, resin with high noble**	$142.00
D6721	Crown, resin with predominantly base metal	$135.00
D6722	Crown, resin with noble**	$137.00
D6740	Crown, porcelain/ceramic **	$300.00
D6750	Crown, porcelain fused to high noble**	$300.00
D6751	Crown, porcelain fused to predominantly base metal	$300.00
D6752	Crown, porcelain fused to noble**	$300.00
D6780	Crown, ¾ cast high noble**	$300.00
D6781	Crown, ¾ cast predominantly base metal	$300.00
D6782	Crown, ¾ cast noble**	$300.00
D6783	Crown, ¾ porcelain/ceramic **	$300.00
D6790	Crown, full cast high noble**	$300.00
D6791	Crown, full cast predominantly base metal	$300.00
D6792	Crown, full cast noble**	$300.00
D6794	Crown - titanium	$300.00
D6930	Recement fixed partial denture	$23.00
D6980	Fixed partial denture repair, restorative material failure	$0.00

Oral Surgery

Includes sutures and clotting agents; extractions include minor smoothing of bone.

D7111	Extraction, coronal remnants - deciduous tooth	$19.00
D7140	Extraction, erupted tooth or exposed root	$65.00
D7210	Surgical removal of erupted tooth	$75.00
D7220	Removal of impacted tooth, soft tissue	$100.00
D7230	Removal of impacted tooth, partially bony	$125.00
D7240	Removal of impacted tooth, completely bony	$160.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$160.00
D7250	Surgical removal residual tooth roots, cutting procedure	$75.00
D7285	Biopsy of oral tissue, hard (bone, tooth)	$50.00
D7286	Biopsy of oral tissue, soft	$60.00
D7310	Alveoplasty with extractions, 4+ teeth, quadrant	$74.00
D7311	Alveoplasty with extractions, 1-3 teeth, quadrant	$65.00
D7320	Alveoplasty, w/o extractions, 4+ teeth, quadrant	$121.00
D7321	Alveoplasty, w/o extractions, 1-3 teeth, quadrant	$102.00
D7410	Excision of benign lesion, up to 1.25	$47.00
D7411	Excision of benign lesion, over 1.25	$72.00
D7412	Excision of benign lesion, complicated	$94.00
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25	$223.00
D7451	Removal, benign odontogenic cyst/tumor, over 1.25	$305.00
D7460	Removal, benign nonodontogenic cyst/tumor, to 1.25	$63.00
D7461	Removal, benign nonodontogenic cyst/tumor, 1.25+	$101.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$300.00
D7472	Removal of torus palatinus	$328.00
D7473	Removal of torus mandibularis	$310.00
D7510	Incision & drainage of abscess, intraoral soft tissue	$80.00

Oral Surgery

Includes sutures and clotting agents; extractions include minor smoothing of bone.

D7520	Incision & drainage, abscess, extraoral soft tissue	$50.00
D7910	suture of recent small wounds up to 5 cm	$0.00
D7911	complicated suture - up to 5 cm	$0.00
D7912	complicated suture - greater than 5 cm	$0.00
D7960	Frenulectomy (frenectomy or frenotomy), separate procedure	$102.00
D7970	excision of hyperplastic tissue - per arch	$50.00
D7999	Unspecified oral surgery procedure, by report	$0.00

Orthodontics (only when provided by participating orthodontist)

For Pediatric Dental EHB, orthodontic treatment is a benefit of this Dental Plan ONLY when the patient's orthodontic needs meet medically necessary requirements as determined by a verified score of 26 or higher (or other qualifying conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.
Orthodontic Diagnostic Records

	Beginning Records	$200.00
	Intraoral - complete series (including bitewings)	
	Panoramic Image	
	Tomographic survey	
	Cephalometric x-ray and tracing for orthodontic purposes	
	Oral/facial photographic images	
	Diagnostic casts for orthodontic purposes	
	Final Records	
	Intraoral - complete series (including bitewings)	$150.00
	Diagnostic casts for orthodontic purposes	

Comprehensive Orthodontic Treatment

(24 months of Usual and Customary Orthodontic Treatment)

D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000.00

Other Orthodontic Services

	Pre-orthodontic treatment visit	$0.00
	Periodic orthodontic visits (as part of the contract)	$0.00
	Broken appointment (less than 24 hour notice)	$15.00

Adjunctive General Services

D9110	Palliative (emergency) treatment, minor procedure	$25.00
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$7.00
D9211	Regional block anesthesia	$8.00
D9212	Trigeminal division block anesthesia	$12.00
D9215	Local anesthesia with operative/surgical procedure	$6.00
D9220	Deep sedation/general anesthesia, 1st 30 minutes	$70.00
D9221	Deep sedation/general anesthesia, each add 'l 15 minutes	$31.00
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$8.00
D9241	Intravenous conscious sedation/analgesia, 1st 30 minutes	$54.00
D9242	IV conscious sedation/analgesia, each add 'l 15 minutes	$26.00
D9248	Non-intravenous conscious sedation	$34.00
D9310	Consultation, other than requesting dentist	$23.00
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	office visit - after regularly scheduled hours	$25.00
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$0.00
D9999	Unspecified adjunctive procedure, by report	$0.00

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