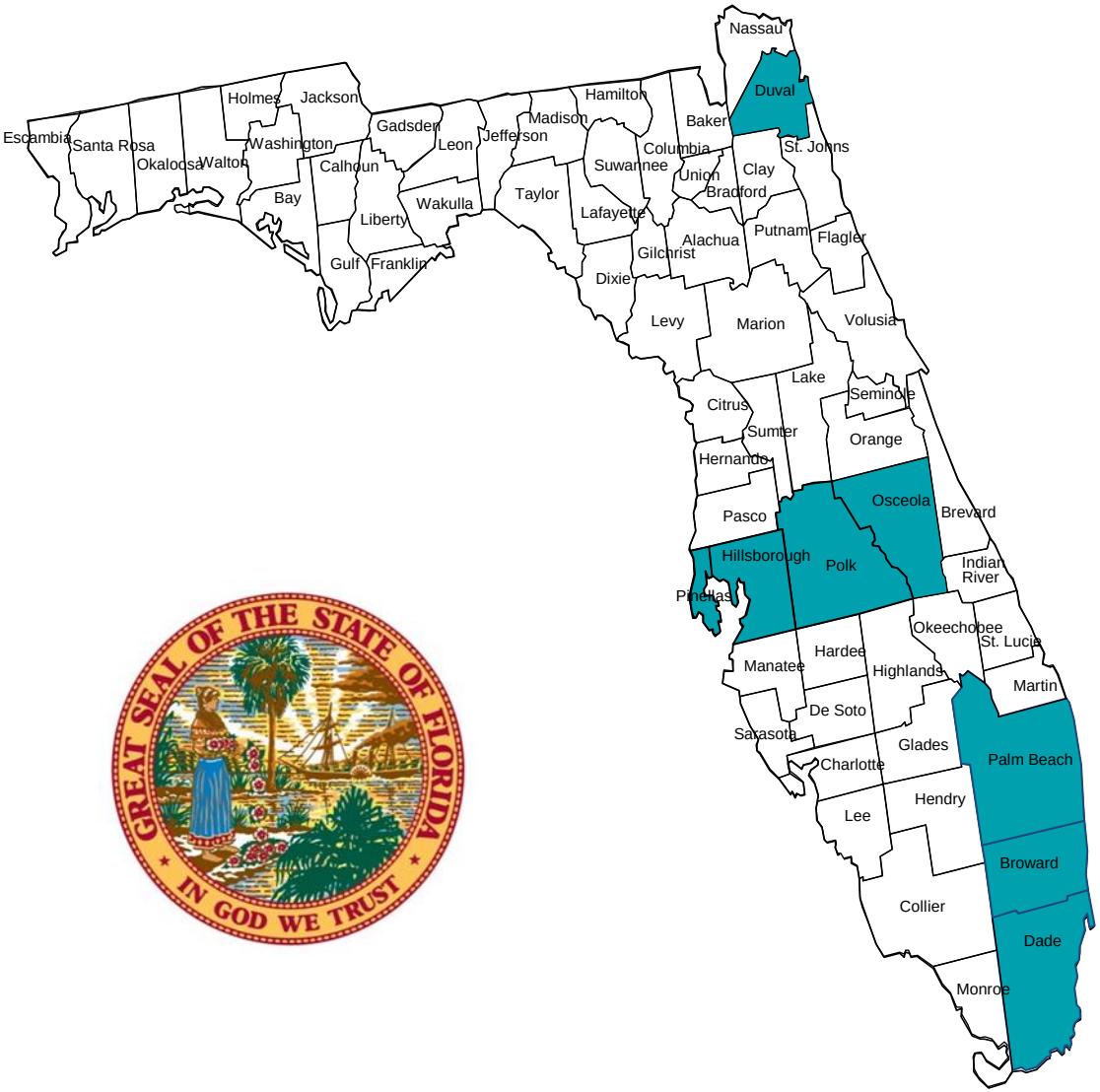
MOLINA® HEALTHCARE

Your Extended Family.

2017 Health Insurance MarketPlace

Marketplace Service Area



2016:
3 Counties:
Broward, Miami-Dade, Palm Beach

2017:
8 Counties:
Broward, ***Duval***, ***Hillsborough***, Miami-Dade, ***Osceola***, ***Pinellas***, Palm Beach, ***Polk***

Counties in **BOLD** are Effective 01/01/17

Affordable Care Act (ACA) Overview

- The Affordable Care Act (ACA) was passed in March of 2010 and due to the number of provisions included in the ACA, it is not expected to be fully implemented until 2020.

Affordable Care Act (ACA) Overview

- Under the ACA, an individual mandate requires individuals who do not have employer sponsored coverage, and do not qualify for Medicare or Medicaid, to purchase insurance coverage or pay a penalty.

Note: *Individuals may be exempt from penalty for reasons of religion or financial hardship as accepted by the* ***Internal Revenue Service (IRS)***.

- As a result of the individual mandate, the ACA created the Health Insurance Marketplace (also known as Health Insurance Exchange).

Affordable Care Act (ACA) Overview

Additional Provisions include but are **not limited** to:

- Insurers cannot deny coverage due to pre-existing conditions.
- Individuals of the same age and geographical location must be offered the same premium price regardless of gender or pre-existing conditions (excluding tobacco use).
- Coverage is no longer limited by annual and lifetime dollar maximums.
- Children may remain covered under their parents insurance until age 26.

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Health Insurance Marketplace

Health Insurance Marketplaces are state or federally governed websites that are designed to provide an affordable alternative to buying coverage directly from private insurers.

In Florida individuals use the Federal Marketplace located at:

www.healthcare.org

Health Insurance Marketplace

They connect individuals to all the participating, private insurers in an individual's area and with one application submission, eligible individuals can:

- Determine if they qualify for reduced costs through the ***Advanced Premium Tax Credit (APTC).***
- Compare coverage options for participating insurers.
- Select a plan to enroll in.*

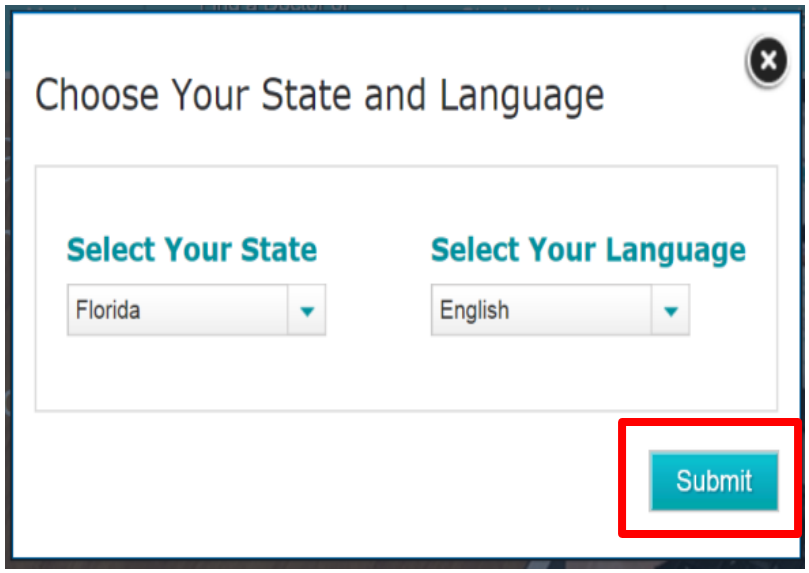
*Members may not yet directly enroll on *molinahealthcare.com*, however, members may request a quote and a licensed agent will contact the member to assist.

Molina Marketplace Website

Members with questions regarding changes to their Molina Marketplace plan, for the 2017 year, should be directed to:

www.molinahealthcare.com

To view information on state-specific Molina Marketplace plans, they will first need to choose a state and language and select submit to proceed.



Eligibility Qualifications

In order to qualify for Marketplace, the potential member has to meet the following conditions:

- Must be a U.S. Citizen or legal immigrant.
- Must not be eligible for Military coverage or public coverage including Medicaid, CHIP and Medicare.
- Cannot be currently incarcerated.

Eligibility Determination

There are only four eligibility determination outcomes:

- Eligible to purchase Marketplace coverage through a Qualified Health Plan.
- Eligible to purchase Marketplace coverage through a Qualified Health Plan and receive subsidies.
- Eligible for Medicaid on the basis of Modified Adjustment Gross Income (MAGI).
- Eligible for Medicaid but not on the basis of MAGI (ex. people with disabilities).

Eligibility Rules

Florida Eligibility Rules	
Dependent Age max	26
Student Age max	30
*Newborn Coverage Period (including DOB)	31 days
Adopted Newborn Coverage Period (including placement date)	31 days

Newborn and Adopted Child Eligibility Rules

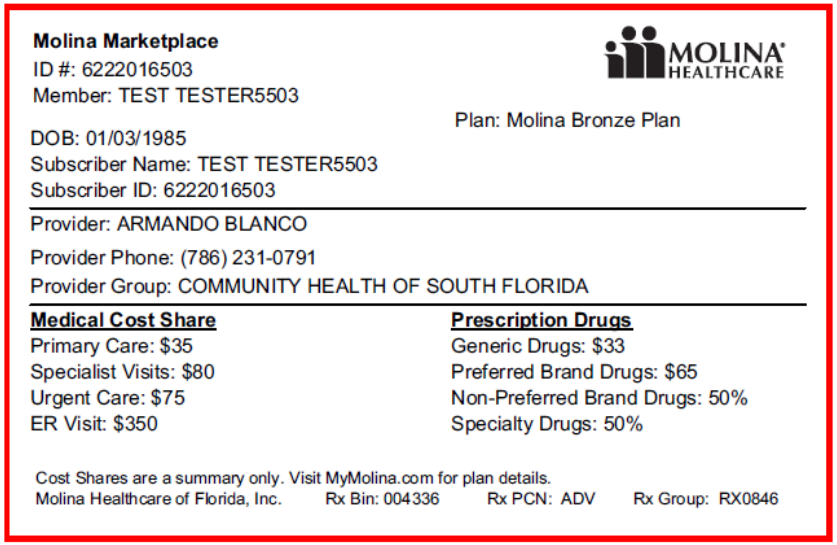
- If the member enrolls the newborn child within 31 days of birth, no additional Premium will be charged for the first 31 days. If the member does not enroll the newborn child within 31 days of birth, but enrolls the child within 60 days of the birth, the child will be covered from the date of birth. The member will be required to pay Premium for the child from the date of birth.

- If a member adopts a child or a child is placed with a member for adoption, then the child is eligible for coverage. The child can be added during the open enrollment period, within 60 days of the child's adoption or within 60 days of the child's placement for adoption. The child's coverage shall be effective on the date of adoption, placement for adoption or as otherwise determined by the Marketplace, in accordance with applicable state and federal laws.

Molina Marketplace ID Card

Two numbers on Molina Marketplace ID Cards:

- **Member ID*** which is the unique ID for each member of the family.
- **Subscriber ID** which is the unique number assigned to the family.



*This is the number the providers would use to bill Molina for services

Verifying Member Eligibility on Web-Portal

- After logging in:
  - Select "Member Eligibility"

650555077 - Other Lines Of Business - xxx4236 - ISRAEL D ALVAREZ MD

MOLINA HEALTHCARE Provider Self Services

Welcome, Support User : MarshalS Log Out

Jan 15 2015 11:45:01 AM

Home Provider Search FAQ Training Contact Molina

Provider Portal

- Member Eligibility
- Claims
- Service Request/Authorization
- Member Roster
- HEDIS Profile New!
- Reports
- Links
- Forms
- Account Tools

Messages and Announcements

You have (0) new messages

You have (2) announcements

Recent Activity

You have 7 Service Request Authorizations in the last 30 days

You have 28 claims in the last 30 days

Quick Member Eligibility Search

Search by Member ID Go

What's New

Medicare is available for Member eligibility searches, Service/Request authorization Inquiry and Claim Status inquiry.Please click Contact Molina to locate the molina medicare member services telephone number.

Video

3:07

Take a tour at our new Provider Self Services!

Poll

Do you like our new look?

Yes
No
None
NA

Vote See Responses

My Favorites

Member Eligibility
Create Professional Claims
Create Institutional Claim
Claim Status Inquiry
Claims Download Report
Create Service Request/Autho..
Service Request/Authoriz atio..
Member Roster

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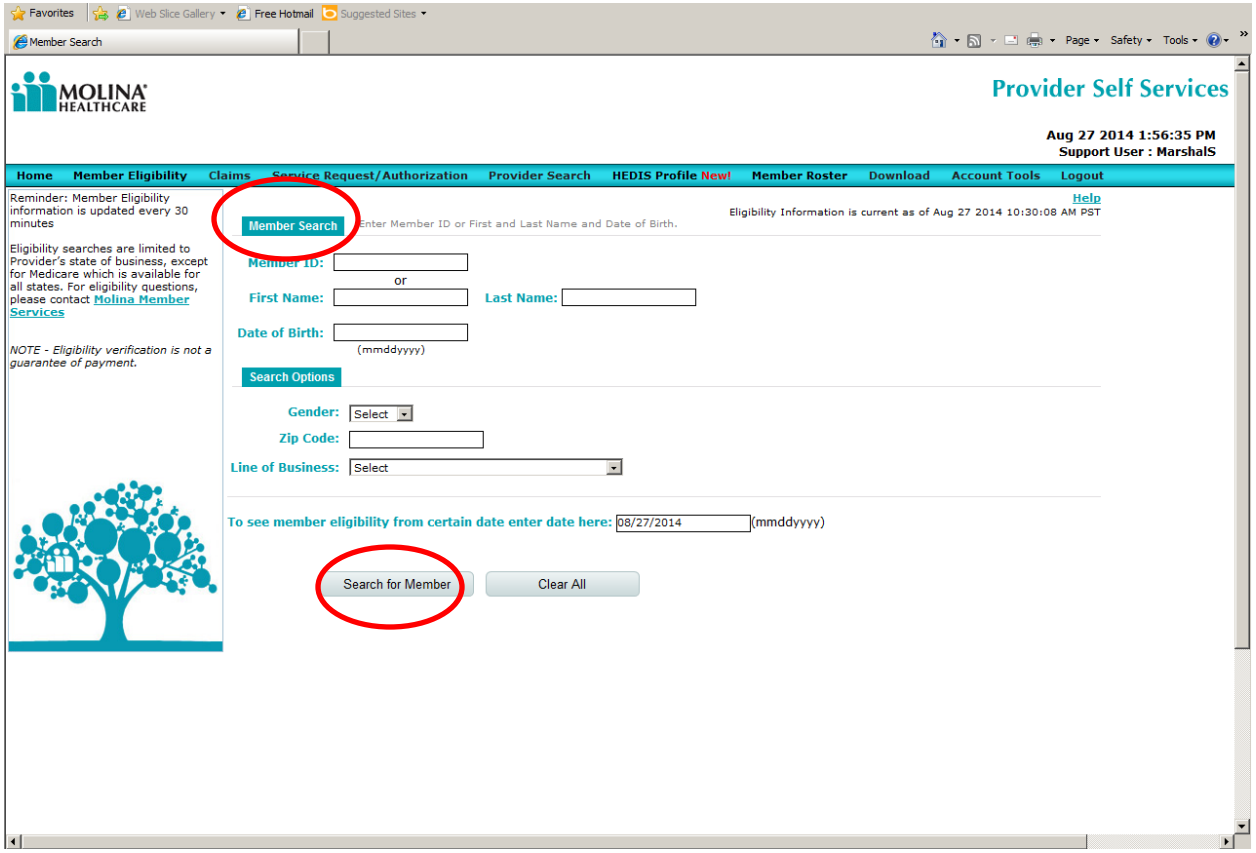
Verifying Member Eligibility on Web-Portal



- **Member Search**:
  - Enter Member ID or
  - Member First and Last Name and Date of Birth

Select "Search for Member"

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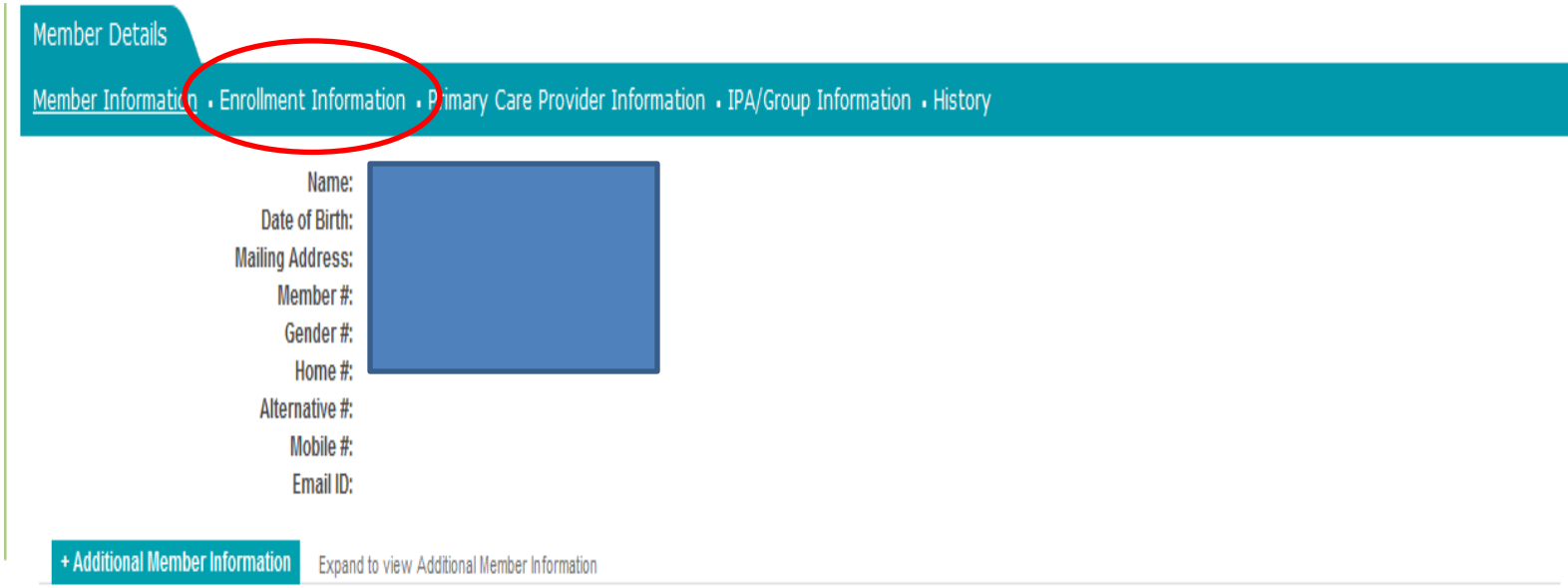
Verifying Member Eligibility on Web-Portal



- **Member Information** will reflect member's:

  - Name
  - Date Of Birth
  - Mailing Address
  - Member ID Number

Select "Enrollment Information" to see details of member enrollment.

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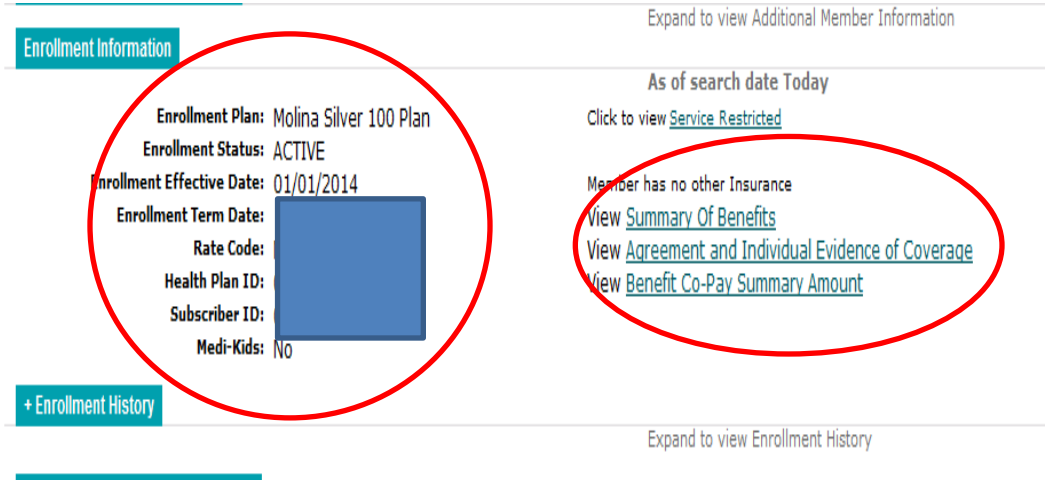
Verifying Member Eligibility on Web-Portal



- **Enrollment Information** will reflect:
  - Enrollment Plan
  - Enrollment Status
  - Effective Date
  - Health Plan ID
  - Subscriber ID
- **Links to Member's**:
  - Summary of Benefits
  - Evidence Of Coverage (EOC)
  - Benefit Co-Pay Summary Amount

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Enrollment and Coverage Dates

The coverage date depends on the day the member enrolled and makes the first premium payment, also known as a binder payment.

Enrollment	Date	Coverage is effective*
On or before	December 15, 2016	January 1st, 2017
Between the	15th and 31st of December	February 1st, 2017
Between the	1st and the 15th of January	February 1st, 2017
Between the	16th and the last day of January February 15th	March 1st, 2017

Key Point
Eligibility is not automatically started on the first of the next month

Key Florida Marketplace Product Points

1. Bronze, Silver, and Gold Plans Offered
2. Silver 100-150 Plans have the ***lowest cost sharing*** to attract target market
3. All covered services that have cost sharing accrue to the Annual Out-of-Pocket Maximum
4. Extensive coverage of Preventive Care services at ***no charge*** across all metal levels
5. Family Planning – ***no charge*** for counseling, birth control, voluntary sterilization

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Molina Marketplace "Options" Plans

1. Options Bronze and Options Silver Plans Offered Only
2. CMS designed program
3. New for 2017
4. CMS now calls them "Simple Choice" plans
5. Other issuers offer these exact same plan designs, so that members have a new way to comparison shop
6. *Administered exactly the same as the other plans. The only difference is cost-sharing amounts, deductible, and OOPM*
7. Watch out for plans with similar names, such as "Silver 100" and "Options Silver 100"

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Molina Marketplace "Options" Plans

- CMS Standardized Options **Bronze –**
  - CMS Standardized Options Plan waives Deductible for **Only First Three Primary Care or Other Practitioner Office Visits,** all Outpatient MH/SA Services, Preventive Services, Preventive Drugs, Pediatric Vision, Generic Drugs

- Office Visit Cost Shares and Coinsurance are much higher than Molina Bronze

Molina Marketplace "Options" Plans
CMS Standardized Options Silver Plan Comparison

Silver Plan	Benefit Driver	CMS Standard Silver (Options)	Molina FFM Silver
Silver 250% FPL	Deductible	Higher	Lower
	OOP Max	Higher	Lower
	PCP	Higher	Lower
	SPEC	Higher	Lower
	Coinsurance	Lower	Higher
	Generic Rx	Even	Even
Silver 200% FPL	Deductible	Higher	Lower
	OOP Max	Even	Even
	PCP	Higher	Lower
	SPEC	Higher	Lower
	Coinsurance	Lower	Higher
	Generic Rx	Even	Even
Silver 150% FPL	Deductible	Higher	Lower
	OOP Max	Lower	Higher
	PCP	Even	Even
	SPEC	Lower	Higher
	Coinsurance	Even	Even
Silver 100% FPL	Deductible	Higher	None
	OOP Max	Even	Even
	PCP	Higher	Lower
	SPEC	Higher	Lower
	Coinsurance	Lower	Higher
	Generic Rx	Higher	Lower

CMS Standardized Options Silver plans have:

- Higher Deductibles, PCP and Specialty Copays

Molina FFM Silver Plans are:

- Positioned with minimal changes
- Lower overall Out of Pocket costs
- Will be attractive alternatives for our target population

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Enrollment Assistance

- ***Only*** licensed agents can advise / recommend / suggest plans to prospective members.

- Member Service Agents can answer questions regarding current plans for existing members.

Special Enrollment – Exceptions

The Marketplace must allow qualified individuals and enrollees to enroll in a ***Qualified Health Plan (QHP)*** or change from one QHP to another as a result of a qualifying event.

- **31 days** to report the qualifying event
- **60 days** from the qualifying event to select a QHP

Special Enrollment Event
Loss of minimum essential coverage
Gaining or becoming a dependent
Gaining lawful presence
Enrollment errors of the Marketplace
Material contract violations by QHP
Gaining or losing eligibility for premium tax credits or cost sharing reductions
Relocation resulting in new or different QHP selection
American Indians and Alaska Natives (AI/AN) may enroll in a QHP or change from one QHP to another one time per month
Exceptional circumstances

Marketplace Contact Information

Contact information for:

Molina Healthcare and **Healthcare.gov**

Molina Healthcare of Florida Marketplace Providers:
Telephone: (855) 322-4076
TTY: (800) 955-8771
www.molinahealthcare.com

Healthcare.gov
Telephone: (800) 318-2596
TTY: (855) 889-4325
www.healthcare.gov

Marketplace Benefit Types

There are two types of Benefits covered under Marketplace:

Essential Health Benefits

- ***Essential Health Benefits (EHB)*** are benefits that the ACA requires all Qualified Health Plans to provide.

Value Added Benefits

- Value Added Benefits are not required by the ACA nor any other regulative authority and are considered a "selling point" to encourage members to enroll with Molina.

Marketplace Required Benefits

All ***Qualified Health Plans (QHP)***, must include the following **ten** categories of ***Essential Health Benefits (EHB)*** defined by ACA:

1. Ambulatory Patient Services.
2. Emergency Services.
3. Hospitalization.
4. Maternity & Newborn Care.
5. Mental health and substance use disorder services, including behavioral health treatment.
6. Laboratory Services.

Marketplace Required Benefits

All ***Qualified Health Plans (QHP)***, must include the following **ten** categories of ***Essential Health Benefits (EHB)*** defined by ACA:

7. Preventive and wellness services, and chronic disease management.
8. Pediatric Services, including Vision and Dental Care.
    - Molina is not required to offer **pediatric dental** coverage if it is available via the Marketplace through Standalone Dental Plans.
9. Rehabilitative and Habilitative Services.
10. Prescription drugs.

Pediatric Benefits

Pediatric Vision – Covered at **no charge** to children up to age 26.

- Vision Exams – one per year.
- Prescription Glasses (Frames and Lenses) or Prescription Contacts – one per year.

Pediatric Dental Coverage – provided by standalone dental carriers, not Molina.

Transportation

Non-Emergency Medical / Non-Medical Transportation:

Non Emergency Transportation is not covered across all metal plans for 2017.

Cost Share

Similar to commercial plans, members covered under Marketplace will have cost shares (a shared financial responsibility). These include:

Co-Insurance

- Percentage of the cost of a procedure the member must pay.

Co-Payment

- Fixed dollar amount member pays for covered services.

Deductible

- Fixed dollar amount member must pay before insurance will pay.

First Dollar Coverage

- A set number of services where deductibles, co-insurance and co-payments are waived.

Out of Pocket Maximum (OOP Max)

- The maximum dollar amount of Cost Sharing that member will have to pay out of pocket for Covered Services in a calendar year. Cost Sharing includes payments towards Deductibles, Copayments, and Coinsurance.

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Understanding Benefit Accruals

Annual Out of Pocket Maximum – Embedded Approach:

For Individuals:

- ✓ Total amount of Cost Sharing an individual Member will have to pay for Covered Services in a calendar year.
- ✓ Cost Sharing includes payments made towards any Deductibles, Copayments or Coinsurance.
- ✓ Once total Cost Sharing in a calendar year reaches the specified individual Annual Out-of-Pocket Maximum amount, ***Molina will pay 100%*** of the charges for Covered Services for the remainder of the calendar year.

*Amounts paid for services that are not Covered Services ***will not*** count towards the individual Annual Out-of-Pocket Maximum.

Understanding Benefit Accruals

Annual Out of Pocket Maximum – Embedded Approach:

For Family (2 or more Members):

- ✓ Total amount of Cost Sharing that at least two or more Members of a family will have to pay for Covered Services in a calendar year.
- ✓ Cost Sharing includes payments made towards any Deductibles, Copayments or Coinsurance.

Understanding Benefit Accruals

Annual Out of Pocket Maximum – Embedded Approach:

For Family (2 or more Members):

- ✓ 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, ***Molina will pay 100%*** of the charges for Covered Services for all enrolled family Members for the remainder of the calendar year.

*Amounts paid for services that are not Covered Services under this Agreement ***will not*** count towards the family Annual Out-of-Pocket Maximum.

APTC vs. Non-APTC Members

APTC Member:

- Receives Advanced Premium Tax Credits (premium subsidy).

Non-APTC Member:

- Members who are solely responsible for the payment of the full monthly premium amount.

*For APTC members, the Grace Period is **3 months** and **10 days** for Non-APTC members.

Standard Grace Period – APTC Members

In cases where the member has not paid their premium, the member is placed into a Grace Period status and Molina will take the following steps, as defined by ACA:

Pend Claims

For services received during the Months 2 & 3 of grace period

APTC Members Only

Provider Notification

When APTC member enters the grace period

Claims for Months 2 & 3 may not be processed until the outstanding premium is received

Denied claims possible if all outstanding premium due is not received by the end of the 3-month grace period

If Member's overdue premium is not received at end of grace period

Member's coverage will be terminated on last day of Month 1 of Grace Period

Claims for services received during Months 2 & 3 will be denied or recovered*

Member will be responsible for payment of services received

***In the event that the APTC Member is terminated for non-payment of the full premium prior to the end of the grace period, Molina will retroactively deny Claims for services rendered in the second and third months of the grace period, and will issue a re-coup notice to the Provider(s) if appropriate.**

Standard Grace Period – Non-APTC Members

In cases where the member has not paid their premium, the member is placed into a Grace Period status and Molina will take the following steps, as defined by ACA:

Pend Claims

- For services received during the Grace Period (10 Days)
- Non-APTC Members Only

Provider Notification

- When Non-APTC member enters the grace period
- Claims for Grace Period may not be processed until the outstanding premium is received
- Denied claims possible if all outstanding premium due is not received by the end of the 1-month Grace Period

If Member's overdue premium is not received at end of grace period

- Member's coverage will be terminated on last day of Grace Period
- Member will be responsible for payment of services received

Alerts

Whenever a member is in the grace period, Molina Healthcare will have a service alert on the Web Portal, IVR and in the call centers

The alert will provide more specific detail about where the member is in the grace period

Providers should verify both the eligibility status AND any service alerts when checking the eligibility of a Molina Healthcare Marketplace member

Member/Provider Notification of Grace Period

Members

- Notified upon entering of grace period.

Providers

- PCP's and providers who have submitted claims during grace period.
- When member enters Month 2* of grace period.

Provider Notification Details

- **Services rendered during Months 2 & 3 of grace period may be denied or recovered.

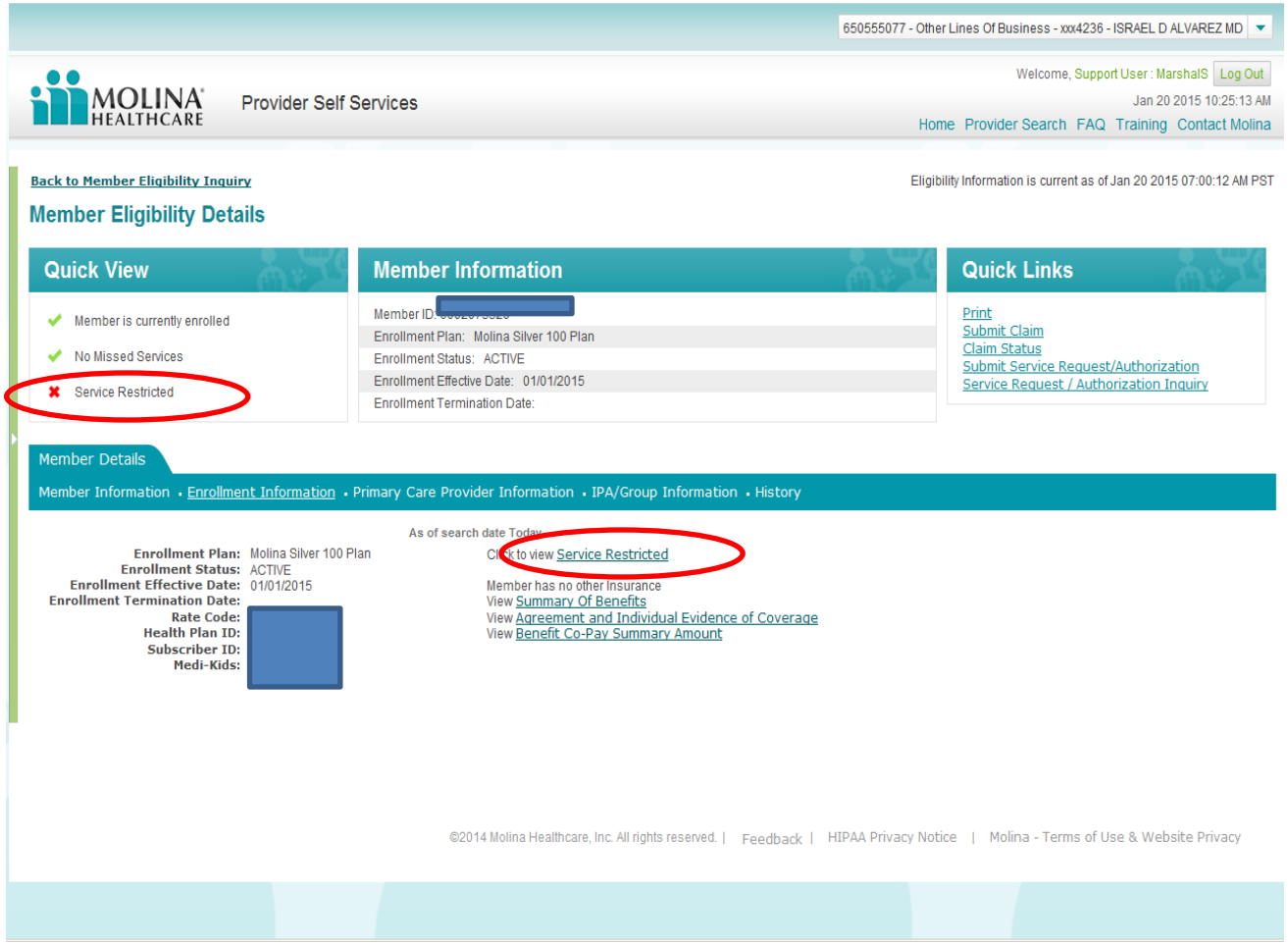
1st Day of GP for Non-APTC Members
****APTC Members only***

Grace Period – Outstanding Balance

If member submits payment and an outstanding balance exists for 2016 premiums, then the payment received will be applied toward that outstanding 2016 balance. The payment can not be applied toward 2017 premium to renew the policy.

All payments must be applied to the oldest outstanding balance to avoid gaps in coverage.

Grace Period Member – Web Portal



Member's account will be flagged as Service Restricted

- Under Enrollment Information - Select "Service Restricted"

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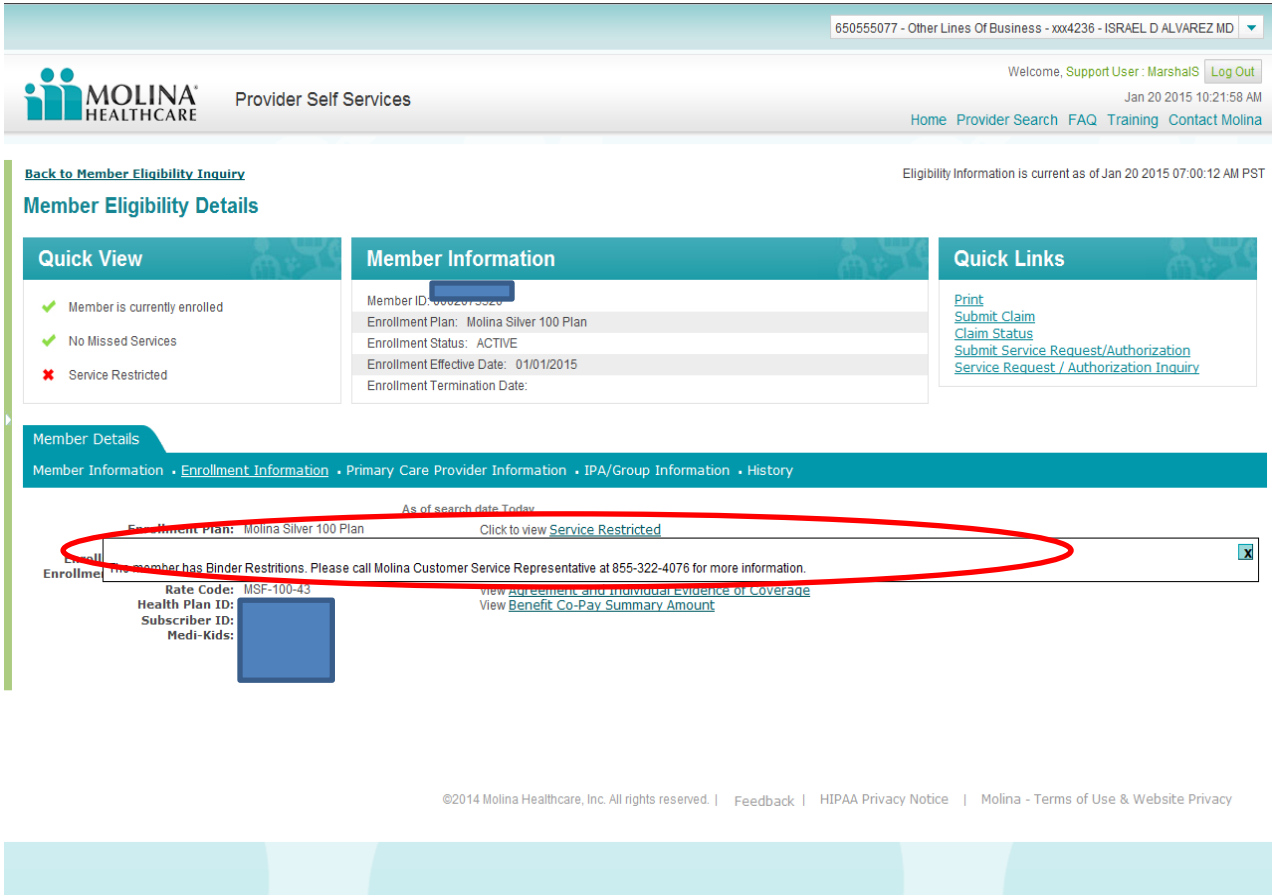
Grace Period Member – Web Portal



- Provider will see member's specific Benefit Restriction.

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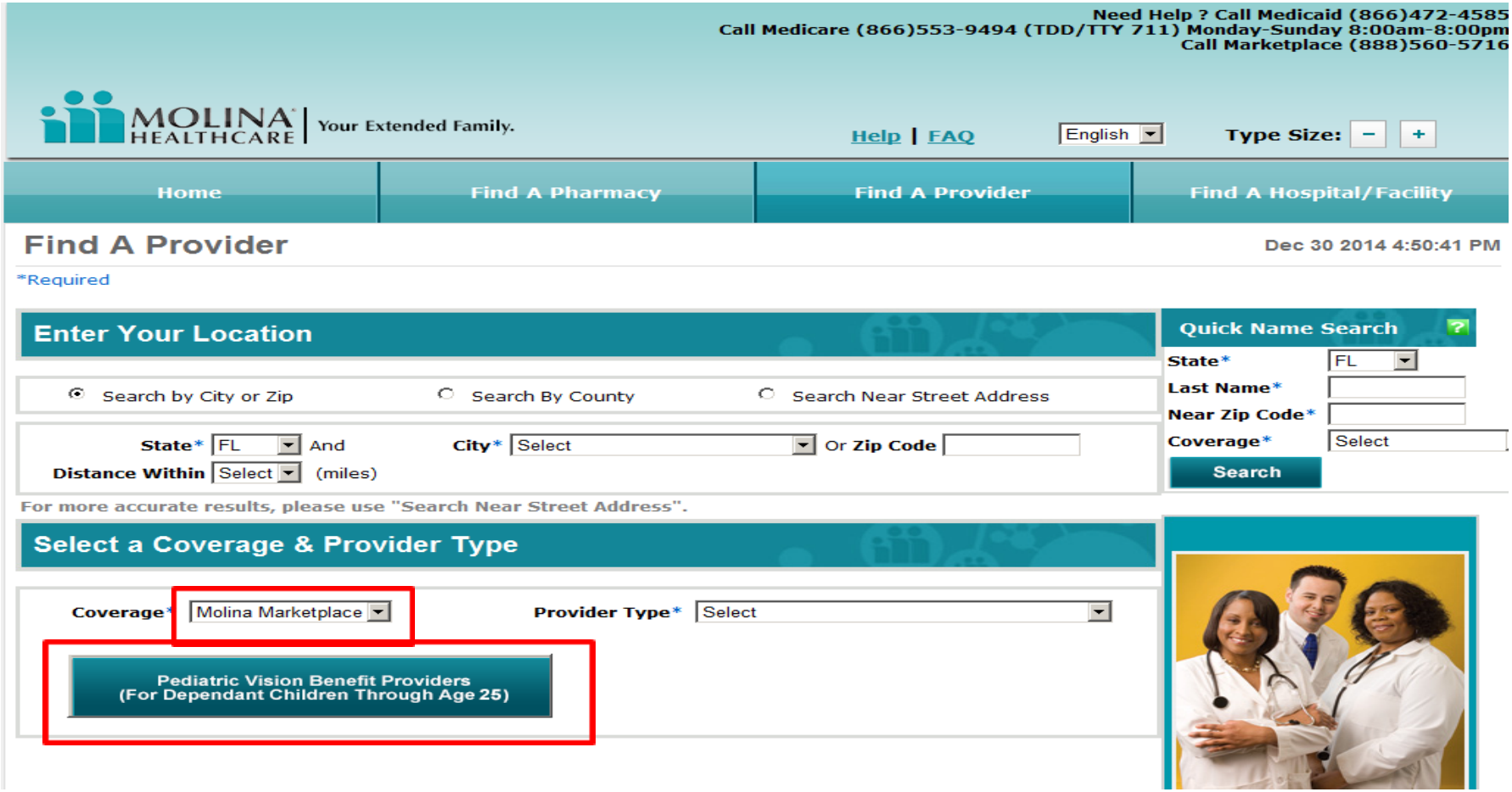
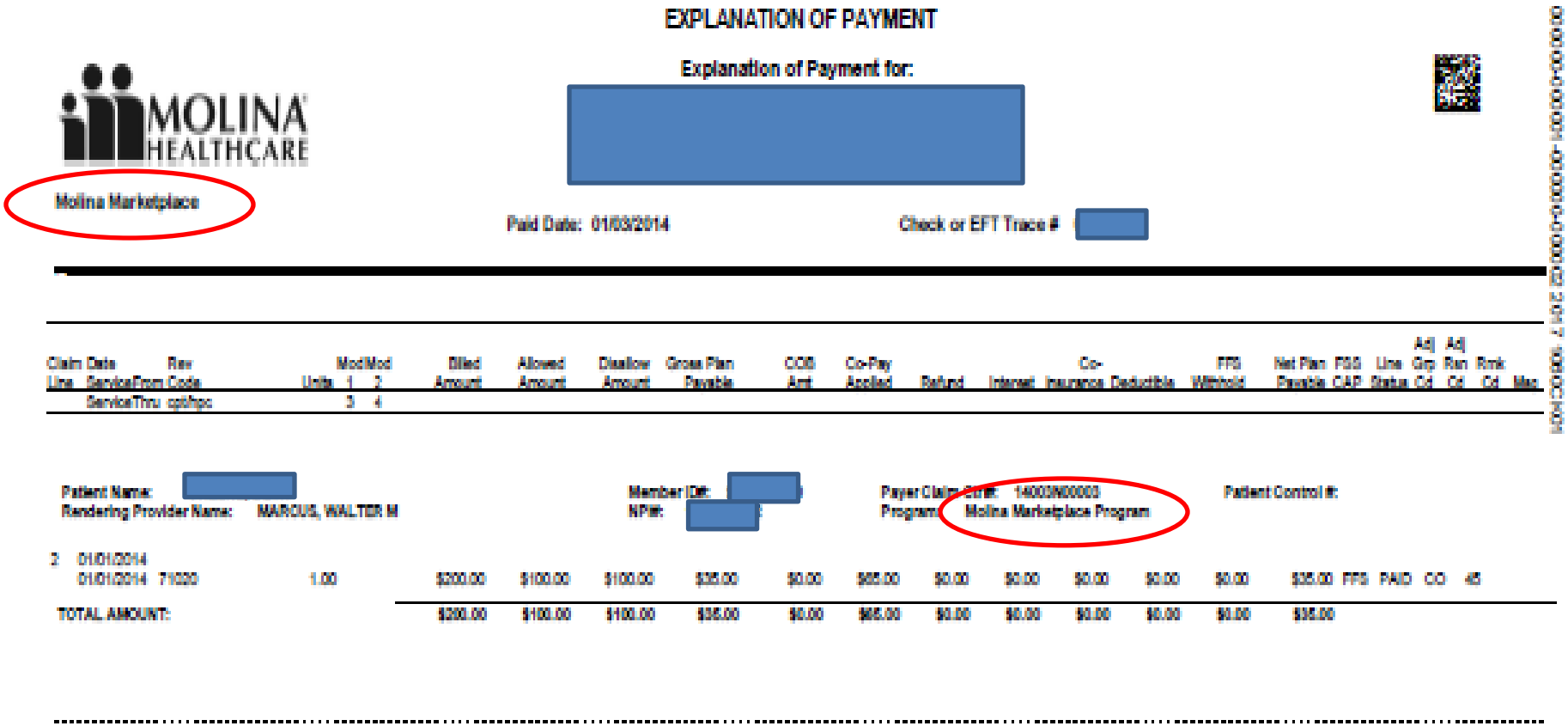
Provider Online Directory



Directory Link:
https://providersearch.molinahealthcare.com/Provider/ProviderSearch?RedirectFrom=MolinaStaticWeb

Marketplace EOP – How to Identify?



EXPLANATION OF PAYMENT

Explanation of Payment for:

[redacted]

MOLINA HEALTHCARE

Molina Marketplace

Paid Date: 01/03/2014

Check or EFT Trace #: [redacted]

Claim Line	Date Service From / Service Thru	Rev Code	Units	Mod 1 / 3	Mod 2 / 4	Billed Amount	Allowed Amount	Disallow Amount	Gross Plan Payable	COB Amt	Co-Pay Applied	Refund	Interest	Co-Insurance	Deductible	FPS Withhold	Net Plan Payable	FSS CAP	Line Status	Adj Grp Cd	Adj Rsn Cd	Rmk Cd	Mac
2	01/01/2014																						
	01/01/2014	71020	1.00			$200.00	$100.00	$100.00	$35.00	$0.00	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$35.00	FPS	PAID	CO	45		
TOTAL AMOUNT:						$200.00	$100.00	$100.00	$35.00	$0.00	$65.00	$0.00	$0.00	$0.00	$0.00	$0.00	$35.00						

Patient Name: [redacted]

Rendering Provider Name: MARCUS, WALTER M

Member ID#: [redacted]

NPI#: [redacted]

Payer Claim Cntrl #: 140003600003

Program: Molina Marketplace Program

Patient Control #:

How to Read Member EOB

Below are descriptions of the fields included on an EOB
Line – denoted which line of the claim the payment and remark information is for. Some claims may contain multiple lines
Service Date – the date the services being billed were performed
Procedure Code – code number of the service that was performed
Billed Amount – amount of billed charges received from provider for service rendered
Allowed Amount – the amount the health plan allows for service rendered
Copay Amount – the amount of member copay for certain benefits (i.e. office visit, ER, etc.). This is a fixed dollar amount
Co-Insurance Amount – The percentage of the allowed amount owed by the member. In some cases, the deductible must first be satisfied before the coinsurance is charged.

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How to Read Member EOB

Below are descriptions of the fields included on an EOB
Deductible Amount – the amount a member must pay out of pocket before Molina will pay for covered services. Deductible amounts vary by plan.
Plan Payment – the amount the health plan has paid to the provider
Remark Code – additional messages that may explain how claim was processed under "Explanations of Claims Handling"
Total Patient Responsibility for This Claim – the amount the member is responsible to pay to the provider
Description of Remark Code – explanation of the claim payment or denial
Family Out of Pocket & Deductible Totals – a summation of a family's total yearly deductible amount and out of pocket amount based on benefits, the Year-to-Date total that have been applied, and the remaining balances

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General Pharmacy Information

- Preferred Drug Listing (PDL)
  - http://www.molinahealthcare.com/providers/fl/marketplace/drug/Pages/formulary.aspx
- Mail order is available (Tiers 1, 2, 3, and 5 only).
- ***Over-The-Counter (OTC)*** - There is currently no OTC program available for Molina Marketplace members.

Requests for Authorization

Providers may submit requests for prior authorization to the Utilization Management Department in the following ways:

Web Portal : https://eportal.molinahealthcare.com/Provider/Login

Marketplace Fax: (866)-440-9791

If submitting via fax, please use the Service Request Form available online, at:

http://www.molinahealthcare.com/providers/fl/marketplace/forms/PDF/prior-authorization-guide-2017.pdf

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Claims

Providers may submit claims to Molina Healthcare on paper or electronically, using a current version CMS-1500, UB-04 or the electronic equivalent. Providers may also use our Web Portal to submit claims.

Medicaid/Marketplace Claims Submission Address

Molina Healthcare of Florida
P.O. Box 22812
Long Beach, CA 90801

Medicare Claims Submission Address

Molina Medicare
P.O. Box 22811
Long Beach, CA 90801

EDI Claims Submission – Medicaid, Medicare & Marketplace

Emdeon Payor ID# 51062
Emdeon Telephone (877) 469-3263

Web Portal
https://eportal.molinahealthcare.com/Provider/Login

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Timely Filing

F.S. 641.3155 requires that all Marketplace providers submit all claims within six (6) months of the date of service. Network providers must make every effort to submit claims for payment in a timely manner, and within the statutory requirement.

Corrected Claims may be submitted at any time during the timely filing period of the provider contract, or within 35 days of the claim Paid Date, if the filing period has expired.

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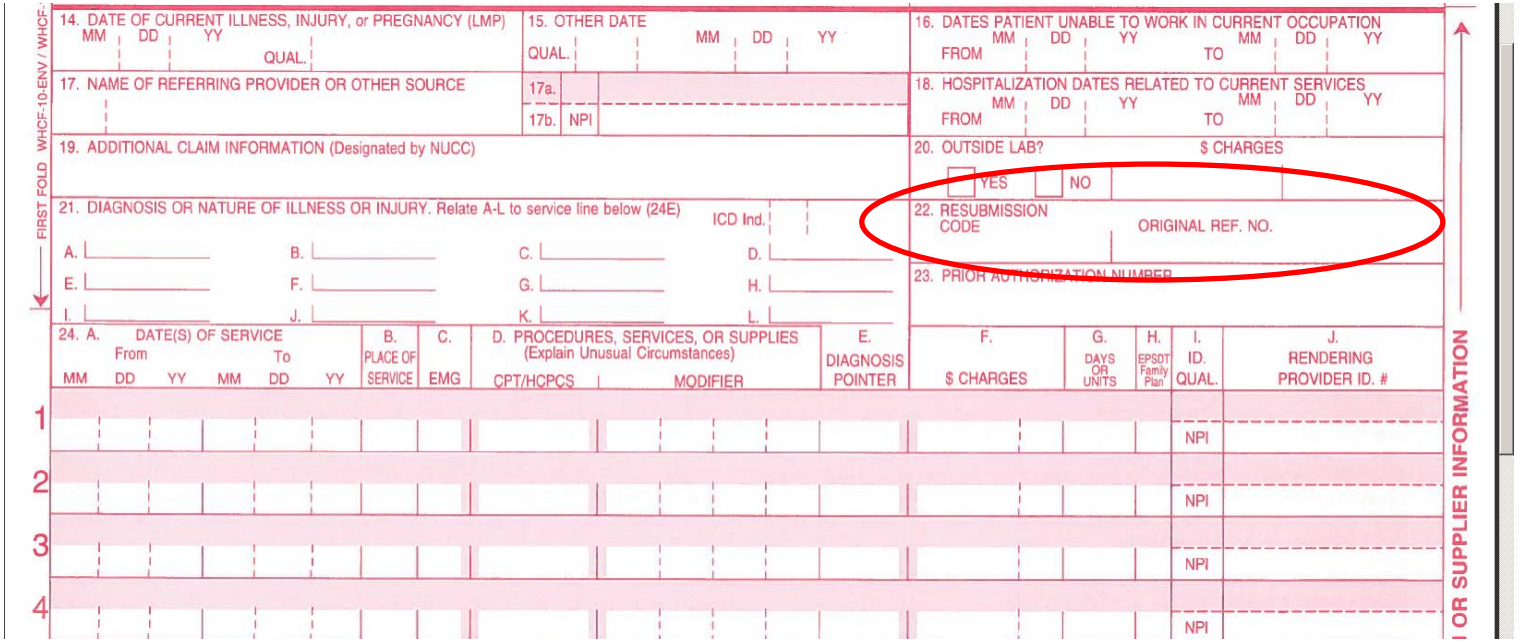
Corrected Claims – CMS-1500



- Box 22 – Use one of the following resubmission codes:
  - (**7**) Replacement of prior claim
  - (**8**) Void/cancel of prior claim
- Box 22A (Original Ref No.) – Report the original claim number

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Corrected Claims – 837P (Electronic/Clearinghouse)

- Loop 2300, CLM Segment, CLM05-3 (Claim Frequency Code) – Use one of the following resubmission codes:
  - (**7**) Replacement of prior claim
  - (**8**) Void/cancel of prior claim

- Loop 2300 (REF Segment) – Report the original claim number

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Corrected Claims – UB04

Providers must utilize the correct Type of Bill Frequency Code to indicate corrected claim.

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Provider Disputes

Any disagreement regarding the processing, payment or non-payment of a claim is considered a Provider Dispute. To file a Provider Dispute, providers may contact Customer Service at (855) 322-4076, or send the request for review in writing, along with any supporting documentation to the address below:

Molina Healthcare of Florida
Attn: Provider Disputes
P.O. BOX 527450
Miami, FL 33152-7450
Fax: 877-553-6504

Provider Disputes must be received within one (1) year of the date of payment or denial of the claim. All provider disputes will be reviewed confidentially, and the outcome will be communicated in writing within sixty (60) days or receipt of the Provider Dispute.

If the Provider Dispute results in an unfavorable decision, and the provider has additional documentation supporting their position, the provider may resubmit the Provider Dispute for secondary review. In the alternative, providers may also request a review of their original appeal by the State's independent dispute resolution organization, listed below:

Maximus Federal Services State Appeals Process
50 Square Drive Suite 120
Victor, NY 14564
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MOLINA® HEALTHCARE
Your Extended Family.

Evidence Of Coverage (EOC)

Molina Healthcare of Florida's Evidences Of Coverage are written specifically to address the requirements of delivering healthcare services to Molina Healthcare Marketplace members, including your responsibilities as a participating provider. Providers may request printed copies of the respective Metal EOC's, at no cost, by contacting Provider Services at (855) 322-4076, or view them on our website, at:

http://www.molinahealthcare.com/members/fl/en-US/mem/marketplace/coverd/Pages/allplans.aspx

MOLINA® HEALTHCARE

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Molina 2017 Benefits At-A-Glance: RENEWAL PLANS

	Bronze	Silver 100	Silver 150	Silver 200	Silver 250	Gold
Features (individual/family)						
Medical Deductible	$6,650/$13,300[1]	$0	$500/$1000[2]	$2,275/$4,550[2]	$2,400/$4,800[2]	$1,025/$2,050[2]
Prescription Drug Deductible		N/A	N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$7,150/$14,300	$1,250/$2,500	$2,250/$4,500	$5,700/$11,400	$7,150/$14,300	$7,150/$14,300
Benefits[3]						
Emergency and Urgent Care Services						
Emergency Room[4]	$350 copay ▲	$150 copay	$205 copay	$400 copay	$400 copay	$300 copay
Urgent Care	$75 copay ▲	$15 copay	$30 copay	$60 copay	$75 copay	$60 copay
Outpatient Professional Services and Office Visits[5]						
Preventive Care	No Charge					
Prenatal Visit						
Well Child Visit						
Family Planning						
Primary Care	$35 copay	$0 copay	$10 copay	$20 copay	$20 copay	$15 copay
Specialty Care	$80 copay ▲	$10 copay	$30 copay	$55 copay	$55 copay	$35 copay
Other Practitioner Care	$35 copay	$0 copay	$10 copay	$20 copay	$20 copay	$15 copay
Habilitative Care	40% coins ▲	10% coins	20% coins	30% coins	30% coins	20% coins
Rehabilitative Care	40% coins ▲	10% coins	20% coins	30% coins	30% coins	20% coins
Mental Health Services	$35 copay	$0 copay	$10 copay	$20 copay	$20 copay	$15 copay
Substance Abuse services	$35 copay	$0 copay	$10 copay	$20 copay	$20 copay	$15 copay
Pediatric Vision Services[6]						
Vision Exam	No charge					
Glasses						
Contacts						

Red lettering indicates changes from 2016 plan design

▲= Deductible Applies

1. Combined medical and pharmacy deductible (waived for preventive care, preventive drugs, generic drugs, hospice, primary care office visits, other practitioner office visits, mental health/substance abuse office visits).
2. Medical deductible applies only to outpatient hospital / facility and inpatient hospital / facility services (does not apply to outpatient professional).
3. Certain benefits require prior authorization prior to obtaining services.
4. This cost is waived if member is admitted directly to the hospital for inpatient services (refer to inpatient hospital services for applicable cost sharing information).
5. Some outpatient professional services not listed require coinsurance rather than a copayment.
6. Applicable to dependent children under age 19.

This "2017 Benefits-At-A-Glance" is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion.
Please consult the Agreement and Individual Evidence of Coverage for a detailed description of benefits, exclusions, and limitations.

Molina 2017 Benefits At-A-Glance: RENEWAL PLANS

Outpatient Hospital / Facility Services	Bronze	Silver 100	Silver 150	Silver 200	Silver 250	Gold
Laboratory Services	$35 copay ▲	$10 copay	$10 copay	$35 copay	$35 copay	$15 copay
Radiology Services	$80 copay ▲	$10 copay	$30 copay	$55 copay	$55 copay	$35 copay
Specialized Scanning Services (CT, MRI, PET Scans)	40% coins ▲	10% coins	20% coins ▲	30% coins ▲	30% coins ▲	20% coins ▲
Medical/Surgical Services	40% coins ▲	10% coins	20% coins ▲	30% coins ▲	30% coins ▲	20% coins ▲
Inpatient Hospital Services						
Medical/Surgical, Maternity Care, Mental Health, Substance Abuse, Skilled Nursing Facility	40% coins ▲	10% coins	20% coins ▲	30% coins ▲	30% coins ▲	20% coins ▲
Hospice Care	No Charge					
Prescription Drugs						
Formulary Generic Drugs	$33 copay	$2 copay	$5 copay	$10 copay	$10 copay	$15 copay
Formulary Preferred Brand Drugs	$65 copay ▲	$15 copay	$30 copay	$55 copay	$55 copay	$50 copay
Formulary Non-Preferred Brand Drugs	50% coins ▲	20% coins	30% coins	40% coins	40% coins	30% coins
Formulary Specialty Drugs	50% coins ▲	20% coins	30% coins	40% coins	40% coins	30% coins
Ancillary Services						
Durable Medical Equipment	40% coins ▲	10% coins	20% coins	30% coins	30% coins	20% coins
Emergency Transportation - Ambulance	40% coins ▲	10% coins	20% coins	30% coins	30% coins	20% coins
Home Healthcare	No Charge ▲	No Charge	No Charge	No Charge	No Charge	No Charge
Other Services						
Dialysis	$80 copay ▲	$10 copay	$30 copay	$55 copay	$55 copay	$35 copay
Supplemental Benefits						
24-Hour Nurse Advice Line	No Charge					
Weight control program						
Motherhood Matters®, mothers-to-be program						
Tobacco counseling, smoking cessation program						

Red lettering indicates changes from 2016 plan design

▲= Deductible Applies

This "2017 Benefits-At-A-Glance" is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion.

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Molina 2017 Benefits At-A-Glance: New Standardized Option Plans

	Options Bronze	Options Silver 100	Options Silver 150	Options Silver 200	Options Silver 250
Features (individual/family)					
Medical Deductible	$6,650/$13,300[1]	$250/$500[2]	$700/$1400[2]	$3,000/$6,000[2]	$3,500/$7,000[2]
Prescription Drug Deductible		N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	$7,150/$14,300	$1,250/$2,500	$2,000/$4,000	$5,700/$11,400	$7,150/$14,300
Benefits[3]					
Emergency and Urgent Care Services					
Emergency Room[4]	50% coins ▲	$100 copay ▲	$150 copay ▲	$300 copay ▲	$400 copay ▲
Urgent Care	50% coins ▲	$25 copay	$40 copay	$75 copay	$75 copay
Outpatient Professional Services and Office Visits[5]					
Preventive Care	No Charge				
Prenatal Visit					
Well Child Visit					
Family Planning					
Primary Care	$45 copay or 50% coins ▲[7]	$5 copay	$10 copay	$30 copay	$30 copay
Specialty Care	50% coins ▲	$10 copay	$30 copay	$55 copay	$55 copay
Other Practitioner Care	$45 copay or 50% coins ▲[7]	$5 copay	$10 copay	$30 copay	$30 copay
Habilitative Care	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Rehabilitative Care	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Mental Health Services	$45 copay	$5 copay	$10 copay	$30 copay	$30 copay
Substance Abuse services	$45 copay	$5 copay	$10 copay	$30 copay	$30 copay
Pediatric Vision Services[6]					
Vision Exam	No charge				
Glasses					
Contacts					

▲= Deductible Applies

1. Combined medical and pharmacy deductible (waived for preventive care, preventive drugs, generic drugs, hospice, mental health/substance abuse office visits, and first three primary care/other practitioner office visits)
2. Medical deductible applies only to outpatient hospital / facility and inpatient hospital / facility services (does not apply to outpatient professional), emergency room, habilitative and rehabilitative services, radiology and lab services, durable medical equipment, emergency medical transportation (ambulance)
3. Certain benefits require prior authorization prior to obtaining services.
4. This cost is waived if member is admitted directly to the hospital for inpatient services (refer to inpatient hospital services for applicable cost sharing information).
5. Some outpatient professional services not listed require coinsurance rather than a copayment.
6. Applicable to dependent children under age 19.
7. For the first three primary care/other practitioner office visits, cost sharing is $45 copay with deductible waived. After the first three visits, cost sharing is 50% coinsurance and is subject to deductible.

This "2017 Benefits-At-A-Glance" is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion. Please consult the Agreement and Individual Evidence of Coverage for a detailed description of benefits, exclusions, and limitations.

Molina 2017 Benefits At-A-Glance: New Standardized Option Plans

Outpatient Hospital / Facility Services	Options Bronze	Options Silver 100	Options Silver 150	Options Silver 200	Options Silver 250
Laboratory Services	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Radiology Services	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Specialized Scanning Services (CT, MRI, PET Scans)	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Medical/Surgical Services	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Inpatient Hospital Services					
Medical/Surgical, Maternity Care, Mental Health, Substance Abuse, Skilled Nursing Facility	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Hospice Care	No Charge				
Prescription Drugs					
Formulary Generic Drugs	$35 copay	$3 copay	$5 copay	$10 copay	$15 copay
Formulary Preferred Brand Drugs	35% coins ▲	$5 copay	$25 copay	$50 copay	$50 copay
Formulary Non-Preferred Brand Drugs	40% coins ▲	$10 copay	$50 copay	$100 copay	$100 copay
Formulary Specialty Drugs	45% coins ▲	25% coins	30% coins	40% coins	40% coins
Ancillary Services					
Durable Medical Equipment	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Emergency Transportation - Ambulance	50% coins ▲	5% coins ▲	20% coins ▲	20% coins ▲	20% coins ▲
Home Healthcare	No Charge ▲	No Charge	No Charge	No Charge	No Charge
Other Services					
Dialysis	50% coins ▲	$15 copay	$25 copay	$65 copay	$65 copay
Supplemental Benefits					
24-Hour Nurse Advice Line	No Charge				
Weight control program					
Motherhood Matters®, mothers-to-be program					
Tobacco counseling, smoking cessation program					

▲= Deductible Applies

This "2017 Benefits-At-A-Glance" is intended to be a summary of covered benefits that lists some features of our plan. It does not list or describe all benefits covered under a specific product or every limitation or exclusion. Please consult the Agreement and Individual Evidence of Coverage for a detailed description of benefits, exclusions, and limitations.

MOLINA HEALTHCARE

Networks

Vision	• **Vision Service Plan (VSP)** • www.vsp.com • Telephone: 800-615-1883
Behavioral Health	• **Beacon Health Options** • www.beaconhealthoptions.com • Telephone: 800-221-5487
Laboratory	• **Quest Diagnostics** • www.questdiagnostics.com • Telephone: 866-MYQUEST (866-697-8378)
Pharmacy Benefits Manager	• **CVS Caremark** • www.caremark.com/wps/portal • Telephone: 800-237-2767

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THANK YOU!!!

For a copy of this presentation, please email:
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