2020

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

Molina 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.

MolinaMarketplace.com

MOLINA® HEALTHCARE
Your Extended Family.

Your Extended Family.

Molina Healthcare (Molina) complies with all Federal civil rights laws that relate to healthcare services. Molina offers healthcare services to all members and does not discriminate based on race, color, national origin, ancestry, age, disability, or sex.

Molina also complies with applicable state laws and does not discriminate on the basis of creed, gender, gender expression or identity, sexual orientation, marital status, religion, honorably discharged veteran or military status, or the use of a trained dog guide or service animal by a person with a disability.

To help you talk with us, Molina provides services free of charge in a timely manner:

- Aids and services to people with disabilities
  - Skilled sign language interpreters
  - Written material in other formats (large print, audio, accessible electronic formats, Braille)
- Language services to people who speak another language or have limited English skills
  - Skilled interpreters
  - Written material translated in your language

If you need these services, contact Molina Member Services. The Molina Member Services number is on the back of your Member Identification card. (TTY: 711).

If you think that Molina failed to provide these services or discriminated based on your race, color, national origin, age, disability, or sex, you can file a complaint. You can file a complaint in person, by mail, fax, or email. If you need help writing your complaint, we will help you. Call our Civil Rights Coordinator at (866) 606-3889, or TTY: 711.

Mail your complaint to: Civil Rights Coordinator, 200 Oceangate, Long Beach, CA 90802.

You can also email your complaint to civil.rights@molinahealthcare.com.

You can also file your complaint with Molina Healthcare AlertLine, twenty four hours a day, seven days a week at: https://molinahealthcare.alertline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can mail it to:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

You can also send it to a website through the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

If you need help, call (800) 368-1019; TTY (800) 537-7697.

03/11/19 - Global

Grievances – The grievance procedure is available in the section of the Agreement titled “Complaints and Appeals.” Please refer to that section for how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the DMHC for review after completing the grievance process or participating in the process for at least 30 days.

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

Usted tiene derecho a recibir esta información en un formato distinto, como audio, braille, o letra grande, debido a necesidades especiales; o en su idioma sin costo adicional.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services. The number is on the back of your Member ID card. (English)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame a Servicios para Miembros. El número de teléfono está al reverso de su tarjeta de identificación del miembro. (Spanish)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電會員服務。電話號碼載於您的會員證背面。(Chinese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi Dịch vụ Thành viên. Số điện thoại có trên mặt sau thẻ ID Thành viên của bạn. (Vietnamese)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa Mga Serbisyo sa Miyembro. Makikita ang numero sa likod ng iyong ID card ng Miyembro. (Tagalog)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 회원 서비스로 전화하십시오. 전화번호는 회원 ID 카드 뒷면에 있습니다. (Korean)

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، المجانًا، لك. تتصل بخدمات الأعضاء. يوجد الهاتف على الجزء الخلفي من بطاقة هوية العضو الخاصة بك. (Arabic)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele Sèvis Manm. W ap jwenn nimewo a sou do kat idantifikasyon manm ou a. (French Creole)

ВНИМАНИЕ: Если вы говорите на русском языке, вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Отдел обслуживания участников. Номер телефона указан на обратной стороне вашей ID-карты участника. (Russian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք խոսում եք հայերեն, կարող եք անվճար օգտվել լեզվի օժանդակ ծառայություններից: Զանգահարե՛ք Հաճախորդների սպասարկման բաժին: Հեռախոսի համարը նշված է ձեր Անդամակցության նույնականացման քարտի ետևի մասում: (Armenian)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
会員サービスまでお電話ください。電話番号は会員IDカードの裏面に記載されております。
(Japanese)

توجه؛ اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، بدون هزینه در دسترس شما هستند. با خدمات اعضا تماس بگیرید. شماره تلفن روی پشت کارت شناسایی عضویت شما درج شده است. (Farsi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਮੈਂਬਰ ਸਰਵਿਸਿਜ (Member Services) ਨੂੰ ਫੋਨ ਕਰੋ। ਨੰਬਰ ਤੁਹਾਡੇ Member ID (ਮੈਂਬਰ ਆਈ.ਡੀ.) ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਪਾਸੇ ਹੈ। (Punjabi)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Wenden Sie sich telefonisch an die Mitgliederbetreuungen. Die Nummer finden Sie auf der Rückseite Ihrer Mitgliedskarte. (German)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez les Services aux membres. Le numéro figure au dos de votre carte de membre. (French)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Cov npawb xov tooj nyob tom qab ntawm koj daim npav tswv cuab. (Hmong)

អ្នកមានសិទ្ធិទទួលបានព័ត៌មាននេះក្នុងទម្រង់ផ្សេង ដូចជា ទម្រង់ជាសម្លេង អក្សរស្ទាប ទំហំអក្សរធំដោយសារតែត្រូវការជាពិសេសរបស់អ្នក ឬជាភាសារបស់អ្នកដោយមិនគិតតម្លៃបន្ថែមឡើយ។ (Cambodian)

CONTENTS

MOLINA HEALTHCARE OF CALIFORNIA
SCHEDULE OF BENEFITS
Molina 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. However, You may receive services from a Non-Participating Provider for Emergency Services, for out-of-area Urgent Care Services, and for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"

American Indians have $0 cost-sharing when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

Deductible Type	At Participating Providers, You Pay
Medical Deductible	
Individual	$6,300
Entire Family of 2 or more	$12,600
Prescription Drug Deductible	
Individual	$500
Entire Family of 2 or more	$1,000
Pediatric Dental Deductible	$0

Annual Out of Pocket Maximum[1]	You Pay
Individual	$7,800
Entire Family of 2 or more	$15,600

[1] 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[2]	40%	Coinsurance per visit, Deductible applies, waived if admitted.
Emergency Physician[2]	No Charge	
Urgent Care	$65	Copayment per visit, Deductible applies after 1st three non-preventive visits

[2] Emergency room combined facility and physician 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[3]	At Participating Providers, You Pay	
Office Visits[4]		
Preventive Care (Includes prenatal, preconception, and first postpartum exam)	No Charge	
Primary Care	$65	Copayment per visit, Deductible applies after 1st three non-preventive visits
Other Practitioner Care	$65	Copayment per visit, Deductible applies after 1st three non-preventive visits
Specialty Physician Care	$95	Copayment per visit, Deductible applies after 1st three non-preventive visits
Habilitative Services	$65	Copayment
Rehabilitative Services	$65	Copayment
Mental/Behavioral Health and Substance Use Disorder Services		
Office Visit	$65	Copayment per visit, Deductible applies after 1st three non-preventive visits
Other Items and Services	$65	Copayment per visit, Deductible applies
Family Planning	No Charge	
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	Please refer to the Pediatric Dental Addendum.	
Orthodontia - Medically Necessary		
Pediatric Vision Services (for Members under Age 19 only)		
Comprehensive Vision Exam (Exam limited to one each calendar year.)	No Charge	
Prescription Glasses *Frames* • Limited to one pair of frames every calendar year • Limited to a selection of covered frames *Lenses* • Limited to one pair of frames every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses • All lenses include scratch resistant coating, and ultraviolet protection (UV)		
Prescription Contact Lenses • In lieu of prescription glasses, prescription contact lenses covered with a minimum three-month supply for any of the following modalities every calendar year: o Standard (one pair annually) o Monthly (six-month supply) o Bi-weekly (three-month supply) o Dailies (three-month supply) • Medically necessary contact lenses for specified medical conditions require Prior Authorization.		
Low Vision Optical Devices and Services (subject to limitations, and Prior Authorization applies)		

[3] Please note, if You are seen in a hospital-based clinic, outpatient hospital Cost Sharing will apply to facility and ancillary charges. Associated professional fees, limited to Evaluation and Management (E&M) services will be processed assessing Your PCP or Specialist Cost Sharing.

[4] For laboratory and diagnostic x-ray services that are provided in a PCP's or Specialist's office, on the same date of service as a PCP or Specialist office visit, You will only be responsible for the applicable Cost Sharing amount for the office visit. Laboratory and x-ray Cost-Sharing, as shown in the Schedule of Benefits, will apply if services are provided by a Participating Provider at a separate location, even if on the same day as an office visit.

Outpatient Hospital / Facility Services	**At Participating Providers, You Pay**	
Outpatient Surgery and Other Procedures		
Professional (Surgery and Non-Surgical Services)	40%	Coinsurance, Deductible applies
Facility(Surgery and Non-Surgical Services)	40%	Coinsurance, Deductible applies
Specialized Scanning Services (CT Scan, PET Scan, MRI)[5]	40%	Coinsurance, Deductible applies
Radiology Services	40%	Coinsurance, Deductible applies
Laboratory Tests	$40	Copayment
Mental/Behavioral Health and Substance Use Disorder (professional and facility services)		
Outpatient Intensive Psychiatric Treatment Programs	$65	Copayment per visit, Deductible applies
Behavioral Health Treatment for Autism Spectrum Disorder (ASD)	$65	Copayment per visit, Deductible applies

[5] Unless Specialized Scanning Services are performed while You are in an inpatient setting, the indicated Cost Sharing amount for these services will apply.

Inpatient Hospital Services	**At Participating Providers, You Pay**	
Facility Fee (e.g., hospital room) • Medical/Surgical • Maternity Care • Mental/Behavioral Health Services • Substance Use Disorder	40%	Coinsurance, Deductible applies
Professional Physician/Surgeon Fee	40%	Coinsurance, Deductible applies
Skilled Nursing Facility (limited to 100 days per benefit period)[6]	40%	Coinsurance, Deductible applies
Hospice Care	No Charge	

[6] Services must be billed by a Skilled Nursing Facility Participating Provider.

Prescription Drug Coverage[7]	**At Participating Providers, You Pay**	
Tier 1	$18	Copayment, Deductible applies
Tier 2	40%	Coinsurance, up to $500 maximum per script, Deductible applies
Tier 3	40%	Coinsurance, up to $500 maximum per script, Deductible applies
Tier 4	40%	Coinsurance, up to $500 maximum per script, Deductible applies
Mail-order Prescription Drugs	Up to a 90-day supply is offered at two times the one-month retail prescription benefit cost share.	

[7] **Please refer to the Prescription Drug Coverage section for a description.** Maximum Cost Sharing of $250 for a 30-day supply of oral chemotherapy drugs, deductible does not apply. Please note, Cost Sharing reduction for any prescription drugs obtained by You through the use of a discount card or

coupon provided by a prescription drug manufacturer, or any other form of prescription drug third-party Cost Sharing assistance, will not apply toward any Deductible or the Annual Out-of-Pocket Maximum under Your Plan. Cost Sharing for covered prescription drugs is limited to be no more than the pharmacy's retail price.

Ancillary Services	At Participating Providers, You Pay	
Durable Medical Equipment	40%	Coinsurance, Deductible applies
Home Healthcare (limited to 100 days per benefit period)[8]	40%	Coinsurance, Deductible applies
Emergency Medical Transportation (Ambulance) (Medically Necessary Emergency Services are covered for Participating and Non-Participating Providers.)	40%	Coinsurance, Deductible applies
Non-Emergency Medical Transportation (Ambulance)	40%	Coinsurance, Deductible applies

[8] Services must be billed by a Home Healthcare Participating Provider agency. Separate Cost Sharing may apply for other Covered Services delivered in the home setting (e.g., injectable drugs, Durable Medical Equipment, etc.).

Other Services	At Participating Providers, You Pay	
Dialysis Services	40%	Coinsurance, Deductible applies

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,**" **"Us,"** 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 Covered Services as described in this Agreement.

This Agreement, amendments to this Agreement, the applicable Schedule of Benefits for this product, 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**. NOTE TO REVIEWER: This document will be printed in English and Spanish.

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

If You are a Molina Healthcare Member, this Agreement tells You what services You can get. If You are thinking about becoming a Molina Healthcare Member, this Agreement 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
MolinaMarketplace.com

TTY users may dial 711

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 Agreement 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 Agreement 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 (PCP)
- 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. TTY users may dial 711

If You move from the address You had when You enrolled with Molina or if You change phone numbers, contact Covered California and or Molina Healthcare at 1 (800) 300-1506.

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 Agreement and is on Our web site at MolinaMarketplace.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

TTY users may dial 711

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 Agreement 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 Agreement, We explain what it means in that section. Words with special meaning used in any section of this Agreement 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.

"Allowed Amount" means the maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing.

Services obtained from a Participating Provider: This means the contracted rate for such Covered Service.

Emergency Services and emergency transportation services from a Non-Participating Provider: Unless otherwise required by law or as agreed to between the Non-Participating Provider and Molina, the Allowed Amount shall be the greatest of 1) Molina's median contracted rate for such service(s), 2) 100% of the published Medicare rate for such service(s), or 3) Molina's usual and customary method for determining payment for such service(s).

All other Covered Services received from a Non-Participating Provider in accordance with this Agreement: This means the lesser of Molina's median contracted rate for such service, 100% of the published Medicare rate for such service, Molina's usual and customary rate for such service, or a negotiated amount agreed to by the Non-Participating Provider and Molina.

"Annual Out-of-Pocket Maximum" (also referred to as "**OOPM**") is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1) the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
2) the family OOPM will be met when Your family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family.

"Child-Only Coverage" means coverage under this Agreement 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 Schedule of Benefits. 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 Schedule of Benefits. 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 Schedule of Benefits at the beginning of this Agreement.

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

"Covered Services" refers to all the healthcare services, including supplies, and prescription drugs covered by this Agreement and that You are entitled to receive from Molina under this Agreement. Covered Services include all Medically Necessary basic health care services and Essential Health Benefits (EHB), in compliance with state and federal law.

"**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 Schedule of Benefits at the beginning of this Agreement.

Please refer to the Schedule of Benefits 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 that are included in the Essential Health Benefits, You will not pay any Deductible or other Cost Sharing towards such preventive services services when provided by a Participating Provider.

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 Agreement.

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

"**Durable Medical Equipment**" or "**DME**" is medical equipment that serves a repeated medical purpose and is intended for repeated use. DME 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 to result in any of the following:

- 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 and Care will not be covered if You did not require emergency services and care and You reasonably should have known that an emergency did not exist.

"**Emergency Services**" or "**Emergency Services and Care**" means medical screening, examination, and evaluation by a physician or surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician or 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 and Care will not be covered if You did not require Emergency Services and Care and You reasonably should have known that an Emergency did not exist.

"**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. Emergency Services and Care will not be covered if You did not require Emergency Services and Care and You reasonably should have known that an Emergency did not exist.

"**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 and chronic disease management
- Pediatric services, including dental***** and vision care for Members up to age 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.

"Exigent" means that a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a nonformulary drug.

"**Medically Necessary**" or "**Medical Necessity**" means health care services that a provider, 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 in accordance with generally accepted standards of 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 or provider. For these purposes, "generally accepted standards" means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant provider community, physician specialty society recommendations, the views of providers practicing in relevant clinical areas, and any other relevant factors. For these purposes, "provider" means a licensed medical, mental health, substance use disorder, or dental provider competent to evaluate the relevant specific clinical issues, or a qualified autism service provider that is licensed, certified, or otherwise authorized under California law.

"**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 Agreement sometimes refers to Molina Healthcare of California as "We", "Us" 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 Provider**" or "**PCP**" who has identified their primary professional designation to Us as a "PCP" is the doctor who takes care of Your health care needs. Your PCP has Your medical history. Your PCP makes sure You get needed health care services. A PCP may refer You to Specialist Physicians or for other services. A PCP 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).
- An individual practice association (IPA) or group of licensed doctors which provides primary care services through the PCP

"Prior Authorization" means Molina's prior determination for Medical Necessity of Covered Services before services are provided for a Member.

"**Referral**" means the process by which the Member's PCP 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 and who has identified their primary professional designation to Us as other than a "PCP" to deliver Covered Services to Members.

"**Spouse**" means the Subscriber's legal husband or wife. For purposes of this Agreement, 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.

Throughout this Agreement, "You" and "Your" may be used to refer to a Member or a Subscriber, as the context requires.

"Telehealth and Telemedicine Services" means:

- Delivery of Covered Services by a Participating Provider through audio and video conferencing

technology that permits communication between a Member at an originating site and a Participating Provider at a distant site, allowing for the diagnosis or treatment of Covered Services.
- The communication does not involve in-person contact between the Member and a Participating Provider. During the virtual visit, the Member may receive in-person support at the originating site from other medical personnel to help with technical equipment and communications with the Participating Provider.
- Services may include digital transmission and evaluation of patient clinical information when the provider and patient are not both on the network at the same time. The Participating Provider may receive the Member's medical information through telecommunications without live interaction, to be reviewed at a later time (often referred to as "Store and Forward" technology). Requirement: When using "Store and Forward" technology, all Covered Services must also include an in-person office visit to determine diagnosis or treatment.

"**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 Covered California and or Molina Healthcare.

For coverage during the calendar year 2020, the initial open enrollment period begins October 15, 2019, and ends January 15, 2020. Your Effective Date for coverage during 2020 will depend on when You applied:

- If You applied on or before December 15, 2019, the Effective Date of Your coverage is January 1, 2020.
- If You applied between December 16, 2019, and January 15, 2020, the Effective Date of Your coverage is February 1, 2020.

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 and or Molina Healthcare, and your reason for eligibility must be verified with documentation that is acceptable to Covered California and or Molina Healthcare. 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 or Molina will provide special monthly enrollment periods for eligible American Indians or Alaska Natives.

The 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. 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 Covered Services)."

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.

Foster Child: A foster child is not eligible for enrollment as a Dependent.

Domestic Partners: If permitted by the Marketplace, a domestic partner of the Subscriber may enroll in this product. The domestic partner must meet any eligibility and verification of domestic partnership requirements established by Covered California and or Molina Healthcare.

Age Limit for Children with Disabilities: 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.

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, or a child only dependent), You must contact Covered California and submit any required application(s), forms and requested information for the Dependent. Requests to enroll a new Dependent must be submitted to 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 sixty (60) calendar 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.
- 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, birth, 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).

Please note: claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and Annual Out-of-Pocket Maximum. However, if an enrollment file is received for the newborn during the first thirty-one (31) calendar days, the newborn will be added as a Dependent as of the date of birth, and any claims incurred by the newborn will be processed as part of the newborn's claims, and any Deductible or Annual Out-of-Pocket Maximum amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or Annual Out-of-Pocket Maximum (i.e., not under the enrolled mother's Deductible and Annual Out-of-Pocket Maximum).

Adopted Child: If You adopt a child or a child is placed with You for adoption, then the child is eligible for coverage under this Agreement. The child can be added to this Agreement during the open enrollment period, within sixty (60) calendar days of the child's adoption or within sixty (60) calendar days of the child's placement with You for adoption. The child's coverage shall be effective on the date of adoption, placement for adoption or as otherwise determined by Covered California, in accordance with applicable State and federal laws and regulations.

Discontinuation of Dependent Covered Services: Covered Services for Your Dependent will be discontinued:

- At the end of the year in which the dependent child attains age 26, unless the child has a disability and meets specified criteria. See the section titled "Age Limit for Children with Disabilities." An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible."
- The date the Dependent Spouse enters a final decree of divorce, annulment, or dissolution of marriage 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

You get a Member identification card (ID card) from Molina Healthcare. We will issue an ID card within ten (10) business days after You make your first payment. 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, you can get a temporary ID card at **MyMolina.com**, and you can request a new ID card at **MyMolina.com** or by calling Molina toll-free at 1 (888) 858-2150. We will be happy to send You a new card. Call Us if You have questions about how to use Your health care benefits.

What Do I Do First?
Look at Your ID card. Check that Your name and date of birth are correct. Your ID card contains basic Cost Sharing information, not including Deductible information, for use by providers. Your ID card also contains the following information:

- Your name (Member)
- Your Member Identification Number (ID #)
- Your date of birth (DOB)
- The toll-free number for Molina's 24-hour Nurse Advice Line
- The toll-free number to Nurse Advice Line for Spanish speaking Members
- The toll-free number for prescription-related questions
- The identifier for Molina's prescription drug benefit
- The toll-free number for hospitals to notify Molina of admissions for Our Members
- The toll-free number for emergency rooms to notify Molina emergency room visits for Our Members

Your ID card is used by health care providers such as Your PCP, 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 Participating Providers and hospitals that are available to You as a Member of Molina Healthcare. You may visit Molina's website at MolinaMarketplace.com to view Our online list of the Participating Providers. You can call Our Customer Support Center to request a paper copy.

Except in an Emergency, the first person You should call for any health care is Your PCP.

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, wherever located.

In general, You must receive Covered Services from Participating Providers; otherwise, the services are not covered, You will be 100% responsible for payment to the Non-Participating Provider and the

payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum. However, You may receive services from a Non-Participating Provider:

1. for Emergency Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services",
2. for out-of-area Urgent Care Services in accordance with the section of the Agreement titled "Emergency Services and Urgent Care Services", and
3. for exceptions described in the section of this Agreement titled "What if There Is No Participating Provider to Provide a Covered Service?"
4. for exceptions described in the section of this Agreement titled "Non-Participating Provider at a Participating Provider Facility"

Telehealth and Telemedicine Services

You may obtain certain Covered Services that are provided through telehealth. In-person contact between You and the doctor is not required for these services, and the type of setting where these services are provided is not limited. For more information, please refer to Telehealth and Telemedicine Services in the definitions section. The following additional provisions apply to the use of Telehealth and Telemedicine Services:

- Services must be obtained from a Participating Provider.
- Services are meant to be used when care is needed now for non-emergency medical issues.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the Member and Participating Provider are in the same physical location.
- Services do not include texting, facsimile or email only.
- Member Cost Sharing is shown in Your Schedule of Benefits.
- Covered Services provided through Store and Forward technology must include an in-person office visit to determine diagnosis or treatment. Please refer to the "Definition" section for explanation.

Here is a chart to help You learn where to go for medical services. The services You may need are listed in the boxes on the left. To find the service You need, look in the box just to the right of it, and You will find out 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 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	Go to any Participating Provider of Your choice. You do not need a Prior Authorization to get these services.

TYPE OF HELP YOU NEED:	WHERE TO GO. WHOM TO CALL.
• Birth control • Sterilization	
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 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 use disorder evaluation	Go to a mental health Participating Provider. You do not need a Referral or Prior Authorization to get a mental health or substance use disorder evaluation.
For mental health or substance use disorder therapy	Go to a mental/behavioral health or substance use disorder Participating Provider. You do not need a referral. You do not need a Prior Authorization for outpatient office visits.
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 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 Urgent Care Services, get help as directed under Emergency Care or Urgent Care Services above.
To get a second opinion	Prior Authorization is required. Please refer to the section of this Agreement titled, "Second Opinions."
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 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 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 MolinaMarketplace.com 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 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 PCP within thirty (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, will be effective the first day of the subsequent 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 PCP 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 MolinaMarketplace.com 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 Us at 1 (888) 858-2150. TTY users may dial 711.

If You are a newly enrolled Member and Your prior coverage was terminated because Your prior plan withdrew that product from any portion of the market or the plan ceased to sell products in any portion of the market, the right to temporary continuity of care, as described above, does apply.

Transition of Care
Molina provides Medically Necessary Covered Services on or after Your effective date of coverage with Molina, not prior. A prior insurer (if there was no break in coverage before enrolling with Molina), may be responsible for coverage until Your coverage is effective with Molina.

After Your effective date with Molina, at Your request, We may allow You to continue receiving Medically Necessary Covered Services for an ongoing course of treatment through completion with a Non-Participating Provider. We may coordinate the provision of Covered Services with any Non-Participating Provider (physician or hospital) on Your behalf for transition of medical records, case management and coordination of transfer to a Molina Participating Provider.

For Inpatient Hospital Services:
With Your assistance, Molina may reach out to any prior insurer (if applicable) to determine Your prior insurer's responsibility for payment of inpatient hospital services through discharge of any inpatient admission. If there is no transition of care provision through Your prior insurer or You did not have coverage through an insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of Your coverage with Molina, not prior.

What If There Is No Participating Provider to Provide a Covered Service?
If there is no Participating Provider that can provide a non-Emergency Covered Service, You may request Prior Authorization to obtain the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the same Covered Services when rendered by Participating Providers. In addition, in the event that Molina becomes insolvent or otherwise discontinues operations, Participating Providers will continue to provide Covered Services under certain circumstances.

Non-Participating Provider at a Participating Provider facility
You may receive Covered Services from a Participating Provider facility at which, or as a result of which, You receive services provided by a Non-Participating Provider. If so, You shall pay no more than the same Cost Sharing that You would pay for the same Covered Services received from a Participating Provider.

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. TTY users may dial 711. Registered Nurses staff the Nurse Advice Line. They are open 24 hours a day, 365 days a year.

Timely Access to Care

Your doctor's office should give You an appointment in the time frames listed below. Exceptions may apply to these timely access standards if the Department of Managed Health Care (DMHC) has found exceptions to be permissible.

Appointment Type	Access Standard
Urgent care appointments not requiring Prior Authorization (including primary care or Specialist Physician)	within 48 hours
Urgent care appointments requiring Prior Authorization (including primary care or Specialist Physician)	within 96 hours
Non-urgent appointments for primary care	within 10 business days
Non-urgent appointments with Specialist Physician	within 15 business days
Non-urgent appointments with a non-physician mental health care providers	within 10 business days
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions	within 15 business days
Telephone triage waiting time	not to exceed 30 minutes

Molina can help you make an appointment, and we provide interpreter services at no cost to You, 24 hours per day. Just call Us toll-free at 1 (888) 858-2150.

PRIOR AUTHORIZATION

What is a Prior Authorization?
A **Prior Authorization** is an approval from Molina for a requested health care service, treatment plan, prescription drug or durable medical equipment. A Prior Authorization confirms that the requested service or item is medically necessary and is covered under Your plan. Molina's Medical Director and Your doctor work together to determine the Medical Necessity of Covered Services before the care or service is given. This is sometimes also called prior approval.

You do not need Prior Authorization for the following services:

- Dialysis (notification only; Prior Authorization is not required; please notify Molina before services are rendered)
- Emergency or Urgent Care Services
- Family planning services
- Habilitative services
- The following rehabilitative services:
  - Cardiac therapy
  - Pulmonary therapy
- Hospice inpatient care (notification only)
- Human Immunodeficiency Virus (HIV) testing & counseling
- Services for sexually transmitted diseases
- Outpatient Mental Health Office Visit Services:
  - Individual and group mental health evaluation and treatment
  - Psychiatric diagnostic evaluation
  - Outpatient services for the purposes of drug therapy
  - Intensive Outpatient Programs (IOP)
- Substance use disorder services:
  - Individual and group substance use disorder counseling
  - Individual substance use disorder evaluation and treatment

    - Group substance use disorder treatment
    - Outpatient services for the purposes of drug therapy
    - Intensive Outpatient Programs (IOP)
- Office - based procedures
- Pregnancy and delivery (notification only; Prior Authorization is not required; please notify Molina before services are rendered)

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
- Approved clinical trials
- Bariatric surgery referral and surgery
- Certain Ambulatory Surgery Center service (ASC)*
- Durable Medical Equipment
- Gene therapy (Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.)
- Genetic counseling and testing
- Injectable drugs and medications not listed on the Molina Drug Formulary
- Outpatient hospital service
- Mental health services:
    - Mental health inpatient services
    - Partial hospitalization
    - Day Treatment
    - Electroconvulsive Therapy (ECT)
    - Neuropsychological and Psychological Testing
    - Behavioral health treatment for Autism Spectrum Disorder (ASD)
- Substance use disorder services:
    - Inpatient services
    - Partial hospitalization
    - Day Treatment
    - Detoxification Services
- Outpatient hospital service
- 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
- Drug quantities that exceed the day-supply limit
- Experimental and Investigational procedures
- Home health care and home infusion therapy - After seven (7) visits for outpatient and home settings
- Hyperbaric Therapy
- Imaging and special tests. Examples are:
    - CT (computed tomography)
    - MRI (magnetic resonance imaging)
    - MRA (magnetic resonance angiogram)
    - PET (positron emission tomography) scan
- Medically Necessary genetic testing
- Pain management care and procedures, except trigger point injections

- Radiation therapy and radio surgery
- The following Rehabilitative Services for office and outpatient settings:
  - Physical Therapy (after initial evaluation plus twelve (12) visits)
  - Occupational Therapy (after initial evaluation plus twelve (12) visits)
  - Speech Therapy (after initial evaluation plus six (6) visits)
- Second opinions from Non-Participating Providers (Refer to the section of this Agreement titled, "Second Opinions")
- Services rendered by a Non-Participating Provider
- Sleep studies (except home sleep studies)
- 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*
- Pediatric dental braces when Medically Necessary*
- Pediatric dental retainers*
- Non-Emergency Air Ambulance
- Any other services listed as needing Prior Authorization in this Agreement.

* Refer to the Pediatric Dental Addendum for full range of Pediatric Dental Services.

The above list of services requiring Prior Authorization is subject to change. You should confirm Prior Authorization requirements before receiving services by calling Us at 1 (888) 858-2150.

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.

Prior Authorization decisions and notifications for medications not listed on the Molina Drug Formulary will be provided as described in the section of this Agreement titled "Access to Nonformulary Drugs"

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. We can explain to You how that type of decision is made. The number is 1 (888) 858-2150. TTY users may dial 711.

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.

We will deny a Prior Authorization if information We request is not provided to Us. 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 section of this Agreement titled "Complaints and Appeals."

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 PCP. Your PCP 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. TTY users may dial 711.

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.

To get a second opinion, call Your PCP. Your PCP can refer You to a Participating Provider for a second opinion. You do not need permission from Molina Healthcare to get a second opinion from a Participating Provider. If there is no provider in the network to give You a second opinion, You may be able to get a second opinion from a Non-Participating Provider. If You ask for a second opinion from a Non-Participating Provider, Molina Healthcare will review and let You know if the second opinion was approved.

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 or think that you do 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.

The second doctor will write a report of what he or she finds. You and Your doctor will get a written report of the second opinion.

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 Services and Care will not be covered if You did not require Emergency Services and Care and You reasonably should have known that an Emergency did not exist.

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. TTY users may dial 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.

What if I Am Away From Molina's Service Area and I Need Emergency Services?
Go to the nearest emergency room for care. Please ask the Emergency room staff to contact Molina and notify Us that You are in the Emergency room. They can call toll-free at **1 (844) 966-5462**. TTY users may dial 711.

- 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 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 emergency room

Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits.

Please be aware You are financially responsible for the cost of non-covered, non-authorized services received from a Non-Participating Provider following stabilization of an Emergency Medical Condition.

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 Rendered 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 Schedule of Benefits. 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.

Important: In the event Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, Molina will calculate the Allowed Amount as the greatest of the following:

1) Molina's usual and customary rate for such services,
2) Molina's median contracted rate for such services, or
3) 100% of the Medicare rate for such services.

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 Case Manager about Your healthcare needs. The Case Manager can help You learn about those needs. The nurse can teach You how to manage them. The Case Manager may also work with Your family or caregiver to make sure You get the care You need. The Case Manager also works with Your doctor to assist with coordinating your care. 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. TTY users may dial 711.

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 (866) 891-2320. We are here Monday through Friday, 6:00 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 Agreement 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 Us at 1 (888) 858-2150. TTY users may dial 711.

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. TTY users may dial 711. 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 seventy-two (72) hours advance notice to arrange for services with a qualified interpreter. Call Molina Healthcare's Customer Support Center via TTY by dialing 711.

Access for Persons with Low Vision or who are blind
You can request this Agreement 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 Agreement is also available in an audio format. For accessible formats, or for direct help in reading the Agreement 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

COVERED SERVICES

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 Agreement, 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 Agreement
- 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 Agreement. 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 Agreement are those described in this Agreement, subject to any exclusions, limitations, and reductions described in this Agreement. 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 in the section of this Agreement titled "Complaints and Appeals."

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 Schedule of Benefits at the beginning of this Agreement.

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 Schedule of Benefits at the beginning of this Agreement.

YOU SHOULD REVIEW THE SCHEDULE OF BENEFITS CAREFULLY. YOU NEED TO UNDERSTAND WHAT YOUR COST SHARING WILL BE.

Annual Out-of-Pocket Maximum

Also referred to as **"OOPM,"** this is the maximum amount of Cost Sharing that You will have to pay for Covered Services in a calendar year. The OOPM amount will be specified in Your Schedule of Benefits. Cost Sharing includes payments that You make toward any Deductibles, Copayments, or Coinsurance.

Amounts that You pay for services that are not Covered Services under this Agreement will not count toward the OOPM.

The Schedule of Benefits may list an OOPM amount for each individual enrolled under this Agreement and a separate OOPM amount for the entire family when there are two or more Members enrolled. When two or more Members are enrolled under this Agreement:

1) the individual OOPM will be met, with respect to the Subscriber or a particular Dependent, when that person meets the individual OOPM amount; or
2) the family OOPM will be met when Your family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a particular Dependent adds up to the individual OOPM amount, We will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year. Once the Cost Sharing for two or more Members in Your family adds up to the family OOPM amount, We will pay 100% of the charges for Covered Services for the rest of the calendar year for You and every Member in Your family.

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 Schedule of Benefits. 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 Schedule of Benefits. 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 Schedule of Benefits.

Please refer to the Schedule of Benefits 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 Schedule of Benefits at the beginning of this Agreement. 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 Agreement, 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 Agreement. However, You are responsible for paying charges for any health care services or treatment, which are <u>not</u> Covered Services under this Agreement.

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 Agreement 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 Agreement. 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 Agreement. 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 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 of this Agreement titled "Complaints and Appeals."

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. Please consult with Your PCP to determine whether a specific service is preventive or diagnostic. You do not pay any Cost Sharing for:

- 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 Agreement 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.

- Alcohol and drug use assessments for adolescents
- All comprehensive perinatal services are covered. This includes perinatal and postpartum care, health management, nutrition assessment, and psychological services.
- Autism screening for children 18-24 months
- Basic vision screening (non- refractive)
- Behavioral health assessment for all sexually active adolescents who are at increased risk for sexually transmitted infections
- 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
- Complete health history
- Depression screening: adolescents
- Dyslipidemia screening for children at high risk of lipid disorder Dyslipidemia screening for children at high risk of lipid disorder
- 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.)
- Fluoride application by a PCP
- Gonorrhea prophylactic medication: newborns
- Health management
- Hearing screening
- Hematocrit or hemoglobin screening
- Hemoglobinopathies screening: newborns
- HIV screening: adolescents at higher risk
- Hypothyroidism screening: newborns
- Immunizations*
- Iron supplementation in children when prescribed by a Participating Provider
- 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.)
- Meeting with the parent, guardian or emancipated minor to talk about the meaning of an exam
- Nutritional health assessment
- Obesity screening and counseling: children
- Oral Health risk assessment for young children (ages 0-10) (1 visit limit per six month period)
- Phenylketonuria (PKU) screening: newborns
- Physical exam including growth assessment
- Screening for hepatitis B virus infection in persons at high risk for infection
- Screening for maternal mental health conditions
- Sickle cell trait screening, when appropriate
- Skin cancer behavioral counseling (age 10 to 24)
- Tobacco use counseling: school-aged children and adolescents
- Tuberculosis (TB) screening
- Well baby/child care

*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.

- Abdominal aortic aneurysm screening: for male former smokers age 65-75
- Alcohol misuse screening and counseling
- Anemia screening: women
- Aspirin for the prevention of preeclampsia
- Aspirin to prevent cardiovascular disease (when prescribed by a Participating Provider)
- Bacteriuria screening: pregnant women
- Behavioral health assessment for all sexually active adults who are at increased risk for sexually transmitted infections
- Blood pressure screening
- BRCA counseling about breast cancer preventive medication
- Breast cancer and chemoprevention counseling for women at high risk
- Breast exam for women (based on Your age)
- Breastfeeding support, supplies counseling
- Cancer screening
- Cholesterol check
- Chlamydial infection screening: women
- Colorectal cancer screening (based on Your age or increased medical risk. Examples of this screening include colonoscopy, and medically necessary periodic stool examinations.)
- Cytological Screening (pap smear) for women every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology.
- Cytologic screening in a hospital or certified lab for the presence of cervical cancer
- Depression screening: adults
- Depression screening: Postpartum women
- 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.)

- Diabetes (Type 2) screening for adults with high blood pressure
- Diet counseling: adults at higher risk for chronic disease
- Dietary evaluation and nutritional counseling
- Exercise to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls
- Family planning services (including FDA-approved prescription contraceptive drugs and devices)
- Folic acid supplementation
- Gonorrhea screening and counseling (all women at high risk)
- Health management and chronic disease management
- Healthy diet counseling
- Hearing screenings
- Hepatitis B screening: pregnant women
- Human papilloma virus (HPV) screening (at a minimum of once every three years for women of age 30 and older.)
- Immunizations
- Medical history and physical exam
- Obesity screening and counseling: adults
- 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
- Osteoporosis screening for women (based on Your age)
- Prostate specific antigen testing
- Rh incompatibility screening: first pregnancy visit
- Rh incompatibility screening: 24-28 weeks gestation
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Screening and counseling for interpersonal and domestic violence: women
- Screening for gestational diabetes
- Screening for hepatitis B virus infection in persons at high risk for infection and pregnant women.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection
- 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.)
- Screening for maternal mental health conditions
- Screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
- Skin cancer behavioral counseling (age 6 months to 24 years)
- Statin preventive medication: adults age 40-75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater
- STDs and HIV screening and counseling
- Syphilis screening and counseling (all adults at high risk)
- Tobacco use counseling and interventions: nonpregnant adults
- Tuberculosis (TB) screening
- Well-woman visits (at least one annual routine visit and follow-up visits if a condition is diagnosed).

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 Health Services
We cover the following outpatient care when provided by Participating Provider physicians or other Participating Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychiatric diagnostic evaluation
- Outpatient services for the purpose of monitoring drug therapy

We cover outpatient mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

"**Mental Disorders**" include the following conditions and those defined in the DSM that result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

- Severe Mental Illness of a person of any age. **"Severe Mental Illness"** means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, Autism Spectrum Disorder (ASD), 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, that 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

- Behavioral health treatment for Autism Spectrum Disorder (ASD), provided that the treatment develops or restores to the maximum extent practicable, the functioning of a person with ASD and that meet all of the following criteria:
  - The treatment is prescribed by a physician or psychologist
  - The treatment is provided under a treatment plan 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 by the Qualified Autism Service Provider
    - A Qualified Autism Service Paraprofessional (see definition below) supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional
  - 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:
    - Delineate both the frequency and baseline behaviors and the treatment planned to address these behaviors
    - 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 and reported
    - Provide intervention plans that utilize evidence based practices, with demonstrated clinical efficacy in treating ASD
    - 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, and administer treatment for ASD and is either of the following:
  - a person who is certified by a national entity (such as the Behavior Analyst Certification Board) with a certification that is accredited by the National Commission for Certifying Agencies
  - a person licensed in California as a physician and surgeon, 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, which may include clinical case management and case

supervision under the direction and supervision of a Qualified Autism Service Provider
- is 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 service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program
- has training and experience in providing services for ASD 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
- is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the treatment plan

- A "**Qualified Autism Service Paraprofessional**" means an unlicensed and uncertified individual who meets all of the following criteria:
  - is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
  - provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
  - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
  - is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the treatment plan

All Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child (SMI or SED) are covered and are not excluded from coverage, notwithstanding any otherwise applicable exclusions or limitations.

Outpatient Substance Use Disorder (SUD) Services
Molina Healthcare covers the following outpatient care for treatment of substance use disorder
- Day-treatment/partial programs
- Intensive outpatient programs
- Individual and group substance use disorder counseling
- Individual substance use disorder evaluation and treatment
- Group substance use disorder treatment

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 Schedule of Benefits.

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

VISION SERVICES

We cover the following vision services for all Members:

- Diabetic eye examinations (dilated retinal examinations)
- Services for medical and surgical treatment of injuries and/or diseases affecting the eye

Benefits are not available for charges connected to routine refractive vision examinations or to the purchase or fitting of eyeglasses or contact lenses, except as described in the section titled, "Pediatric Vision Services."

Pediatric Vision Services
Molina Healthcare covers the following vision services for Members up to age 19:

Exams:

- Routine vision screening and eye exam, including refraction, every calendar year.
- Dilation within the eye exam when professionally indicated.

Prescription glasses:

- Prescription glasses: frames and lenses, limited to one (1) pair of prescription glasses once every calendar year. Eyeglass lenses are available in glass, plastic, or polycarbonate. Single vision, conventional bifocal, conventional trifocal, and lenticular lenses in all lens powers are offered.

Contact Lens Exam (Fitting and Evaluation):

- Standard and Premium fits are covered in full

Materials:

- Prescription contact lenses covered with a minimum three (3) month supply for any of the following modalities:
  - Standard (one (1) pair annually)
  - Monthly (six (6) month supply)
  - Bi-weekly (three (3) month supply)
  - Dailies (three (3) month supply)
- Contact lenses are in lieu of frame and lenses
- Members can choose from any available prescription contact lens material

Necessary Contact Lenses

- Covered in full for members who have specific conditions for which contact lenses provide better visual correction, in lieu of prescription lenses and frames, for the treatment of:
  - Aniridia
  - Aniseikonia
  - Anisometropia
  - Aphakia
  - Corneal disorders
  - Irregular astigmatism
  - Keratoconus
  - Pathological myopia
  - Post-traumatic disorders

  Please refer to the section called "Specialty Vision Services" for coverage of special contact lenses for Aniridia and Aphakia.

- Low vision optical devices including low vision services, training and instruction to maximize remaining usable vision with follow-up care, when services are Medically Necessary and Prior Authorization is obtained. With Prior Authorization, coverage includes:
  - one (1) comprehensive low visions evaluation every five (5) years
  - high-powered spectacles, magnifiers and telescopes as Medically Necessary
  - follow-up care – four (4) visits in any five (5) year period

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.
- All Food and Drug Administration (FDA) approved contraceptive methods including drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the Member's Provider, voluntary sterilization procedures, and patient education and counseling on contraception and follow-up services related to the drugs, devices, products, and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, the Plan is only required to cover at least one (1) therapeutic equivalent without cost sharing. (*Prescription drugs not available on the formulary are available through an exception review process)
- 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 the following diabetes-related services:

- education regarding diabetes care management.
- diabetic eye examinations (dilated retinal examinations)
- routine foot care for Members with diabetes

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 Agreement are necessary. Please contact Us at 1 (888) 858-2150 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. You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

Chemotherapy and Other Provider-Administered Drugs
We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility cost sharing.

Laboratory Tests
We cover the following services when furnished by Participating Providers and Medically Necessary.; These services are subject to Cost Sharing: You must receive these services from Participating Providers. Otherwise, the services are not covered, You will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

- 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:

- Hospital-based intensive outpatient treatment; intensive outpatient program; partial hospitalization
- Multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Treatment in a crisis residential program in licensed psychiatric treatment facility; twenty-four (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 and provided Your coverage with Us has not terminated. Molina will work with You and Your doctor to provide transportation to a Participating Provider facility. If Your coverage with Us terminates during a hospital stay, the services You receive after Your termination date are not Covered Services.

After stabilization and after provision of transportation to a Participating Provider facility, services provided in an out-of-area or Non-Participating Provider facility are not Covered Services, so You will be 100% responsible for payments to Non-Participating Providers, and the payments will not apply to Your Deductible or Your Annual Out-of-Pocket Maximum.

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

Chemotherapy and Other Provider-Administered Drugs
We cover chemotherapy and other provider-administered drugs when furnished by Participating Providers and Medically Necessary. Chemotherapy and other provider-administered drugs, whether administered in a physician's office, an outpatient or an inpatient setting, are subject to either outpatient facility or inpatient facility cost sharing.

Maternity Care
Molina covers medical, surgical and hospital care during the term of pregnancy, along with screening for maternal mental health conditions. This includes prenatal, intrapartum and perinatal care, upon delivery for normal delivery, 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 require that You or Your provider notifies Molina. Please refer to "Maternity Care" in the "Inpatient Hospital Services" section of the Schedule of Benefits 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 and other Participating Providers who are licensed health care professionals acting within the scope of their license.

We cover inpatient hospital mental health services, including services for the treatment of gender dysphoria, only when the services are for the diagnosis or treatment of Mental Disorders. This includes treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis. A "Mental Disorder" is identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

"**Mental Disorders**" include the following conditions and those defined in the DSM that result in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

- Severe Mental Illness of a person of any age. "**Severe Mental Illness**" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, Autism Spectrum Disorder (ASD), anorexia nervosa, or bulimia nervosa

- A Serious Emotional Disturbance of a child under age eighteen (18). A "**Serious Emotional Disturbance**" of a child under age eighteen (18) means a condition identified as a "mental disorder" in the DSM, other than a primary substance use disorder or developmental disorder, that 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

- Autism Spectrum Disorder (ASD) provided that the treatment develops or restores to the maximum extent practicable, the functioning of a person with ASD.

All Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child (SMI or SED) are covered and are not excluded from coverage, notwithstanding any otherwise applicable exclusions or limitations.

Substance Use Disorder (SUD)

Inpatient Detoxification
Molina Healthcare covers hospitalization in a Participating Provider hospital only for detoxification and medical management and treatment of withdrawal symptoms, including room and board, Participating Provider physician services, drugs, dependency recovery services in a medical or behavioral health

facility, education, and counseling.

Residential Treatment Services
Molina Healthcare covers substance use disorder treatment in a nonmedical residential treatment setting approved in writing by Molina Healthcare. These settings provide counseling and support services in a structured environment.

Skilled Nursing Facility
Care in a skilled nursing facility (SNF) is covered when Medically Necessary and referred by Your PCP. Covered SNF services include:

- Room and board
- Physician and nursing services
- Drugs prescribed by a Participating Physician as part of the plan of care in the participating skilled nursing facility in accord with Molina's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
- Durable medical equipment that is covered by Molina if skilled nursing facilities ordinarily furnish the equipment;
- Imaging and laboratory services that skilled nursing facilities ordinarily provide;
- Medical social services;
- Blood, blood products, and their administration;
- Medical supplies;
- Physical, occupational, and speech therapy;
- Respiratory therapy.

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 one-hundred (100) days per benefit period. The skilled inpatient services must be customarily above the level of custodial or intermediate care. A benefit period begins on the date You are admitted to a hospital or SNF at a skilled level of care and ends on the date You have not been an inpatient in a hospital or SNF, receiving a skilled level of care, for sixty (60) consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three (3) day stay in an acute care hospital is not required to commence a benefit period.

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 (7) 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 twelve (12) months or less. They can choose hospice care instead of the traditional services covered by this product. Please contact Molina for further information. Prior Authorization is not required.

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 Agreement 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 Schedule of Benefits.

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 Schedule of Benefits.

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 Schedule of Benefits.

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) 858-2150.
- 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 ninety (90) day time limit for services to treat complications, Molina will continue to pay for Medically Necessary services for donor for ninety (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 Schedule of Benefits. 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 at a plan contracted retail pharmacy unless a prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy. Prescription drugs and medications are 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. The maximum Cost Share for an orally administered anti-cancer medication is $250 for up to a thirty (30) day supply and is not subject to a deductible.
We cover for the human papillomavirus vaccine for female Members who are nine (9) to fourteen (14) 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 Services or Urgent Care Services only.

Please note, Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by You through the use of a discount card or coupon provided by a prescription drug manufacturer, or any other form of prescription drug third-party Cost Sharing assistance, will not apply toward any Deductible or the Annual Out-of-Pocket Maximum under Your Plan.

Any Tier 4 prescription drug that is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination or patient education that cannot be provided by a retail pharmacy is identified on the formulary.

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

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. TTY users may dial 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 (3) 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

Some of the reasons Your drug may not be approved are:

- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Over-the-counter drugs not on the formulary
- Drugs not FDA approved or licensed for use in the United States

You can look at Our Drug Formulary on Our Molina Healthcare website. The address is MolinaMarketplace.com. You may call Molina Healthcare and ask about a drug, including whether a prescription may be obtained at a retail pharmacy. Call toll free 1 (888) 858-2150, Monday through Friday and choose the pharmacy option, 8:00 a.m. through 6:00 p.m. TTY users may dial 711.

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 Nonformulary Drugs
Molina has a process to allow You to request clinically appropriate drugs that are not on the formulary 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.

If You disagree with the denial of a "nonformulary drug" and/or step therapy exception request You can file a grievance requesting an external exception review. Please refer to section titled "Complaints and Appeals" for information on how to file a grievance.

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 (2) 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 nonformulary drugs.
- Standard Exception Request.

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

- Twenty-four (24) hours following receipt of request for Expedited Exception Request
- Seventy-two (72) hours following receipt of request for Standard Exception Request

If initial request is denied for a nonformulary drug" and/or step therapy exception, You can file a grievance requesting an external exception review. Please refer to section titled "Complaints and Appeals" for information on how to file a grievance.

Also, You and/or Your Participating Provider may request an Independent Review Organization (IRO) review. You and or Your Participating Provider will be notified of the IRO's decision no later than:

- Twenty-four (24) hours following receipt of request for Expedited Exception Request
- Seventy-two (72) hours following receipt of request for Standard Exception Request

If You disagree with the denial of a "nonformulary drug" and/or step therapy exception request You, Your representative, or Your provider can file a grievance requesting an external exception review. Information as to how to request a review will also be included in the enrollee's notice of denial. Please refer to section titled "Complaints and Appeals" for information on how to file a grievance. The external exception review process is in addition to the right of the member to file a grievance or request independent medical review. Molina will respond to the external review request within:

- Twenty-four (24) hours following receipt of request for Exigent
- Seventy-two (72) hours following receipt of request for non-urgent

Step Therapy
In some cases, Molina requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, Molina may not cover Drug B unless you try Drug A first. If Drug A does not work for you, Molina will then cover Drug B. Any request for an exception for step therapy can be made at the same time with a prior authorization request for a prescription drug, and will be reviewed within the same timeframes as a prior authorization request, see section titled "Prior Authorization" for more information on Prior Authorization.

Cost Sharing for Prescription Drugs and Medications
The Cost Sharing for prescription drugs and medications is listed in the Schedule of Benefits. 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.

You are not required to pay more than the retail price for a covered prescription drug. If a pharmacy's retail price is less than the applicable Copayment or Coinsurance amount listed on the Schedule of Benefits, the retail price You pay for a covered drug will constitute the applicable Cost Sharing. Your retail-price payment will apply to both the Deductible, if any, and the Annual Out-of-Pocket Maximum.

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
Cost Sharing for Formulary Tier 1 drugs is listed on the Schedule of Benefits.

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.

Tier 2
Cost Sharing for Formulary Tier 2 drugs is listed on the Schedule of Benefits.

Tier 3
Cost Sharing for Formulary Tier 3 drugs is listed on the Schedule of Benefits.

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.

Opioid Analgesics Prescribed for Chronic Pain
If You are prescribed opioid analgesics for chronic pain, You must obtain a Prior Authorization before receiving opioid analgesics for chronic pain, except under the following circumstances:

- Opioid analgesics prescribed to a Member who is a hospice patient in a hospice care program;
- Opioid analgesics prescribed to a Member who has been diagnosed with a terminal condition, but is not a hospice patient in a hospice care program; or
- Opioid analgesics prescribed to a Member who has cancer or another condition.

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, 6:00 a.m. to 6:00 p.m., Monday through Friday. Your PCP helps You decide which stop-smoking drug is best for You. You can get up to a three-(3) 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. You are not required to use mail order services. Formulary Prescriptions drugs can be mailed to You within ten (10) days from order request and approval. Cost Sharing for up to a ninety (90) day supply is at two times Your appropriate Copayment or Coinsurance Cost Share based on Your drug tier for one (1) 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 MolinaMarketplace.com 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 MolinaMarketplace.com 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 TTY users may dial 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. Pen delivery systems for the administration of insulin are also covered.

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 thirty (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 thirty (30) day supply in a thirty (30) day period. The day supply limit for mail order prescription fills is ninety (90) days, as described above in the section titled "Mail order availability of Formulary Prescription Drugs."

Up to a twelve (12) month supply is permitted for an FDA-approved, self-administered hormonal contraceptive when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. The thirty (30) day supply limit and ninety (90) day mail order supply limit do not necessarily apply for the up-to-twelve (12)-month supply for FDA-approved, self-administered hormonal contraceptives. Otherwise, quantities that exceed the day supply limit are not covered unless Prior Authorized.

We cover partial fills for less than the standard thirty (30) day supply for oral, solid dosage forms of Schedule II drugs on the Drug Formulary. We cover partial refills until the prescription has been fully dispensed. Cost Sharing for partial fills will be prorated.

Over-the-Counter Drugs and Supplements
Over-the-counter drugs and supplements that are required by state and federal laws to be covered for preventive care are available at no charge when prescribed by a Participating Provider.
- Folic Acid for women planning or capable of pregnancy
- Vitamin D for community-dwelling adults 65 years and older to promote bone strength
- Iron Supplements for children age 6 to 12 months at increased risk for iron deficiency anemia
- Aspirin for adults for prevention of cardiovascular disease

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 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 (2) 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.

AIDS Vaccine
Molina Healthcare covers vaccine for acquired immune deficiency syndrome (AIDS) if it meets both of the following criteria:
1) It is approved for marketing by the federal Food and Drug Administration; and
2) It is recommended by the United States Public Health Service.

ANCILLARY SERVICES

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

Covered DME 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
- 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 DME 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 Schedule of Benefits to see the Cost Sharing applicable to these devices.

External 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 twelve (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 (2) 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 one hundred (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 Agreement for a description of benefit limitations and applicable exceptions.

TRANSPORTATION SERVICES

Emergency Medical Transportation
We cover Emergency Medical transportation (ground or air ambulance), or ambulance transport services provided through the "911" emergency response system when Medically Necessary or when an enrollee reasonably believes there is an emergency. Covered emergency medical transportation services will be provided at the cost share identified within the Schedule of Benefits.

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, and any other type of non-medical transportation 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 twelve (12) month period to treat aniridia (missing iris), whether provided by the plan during the current or a previous twelve (12) month contract period.
- Up to six (6) 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), whether provided by the plan under the current or a previous contract in 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 Agreement. These exclusions apply to all services that would otherwise be covered under this Agreement 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.

These exclusions or limitations do not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child (SMI or SED).

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 Agreement.

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 the following, are not covered:

- X-rays
- Appliances
- Implants
- Services provided by dentists or orthodontists
- Dental services following accidental injury to teeth
- 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. This exclusion does not apply to services under hospice care or for Covered Services described in the section titled, "Phenylketonuria (PKU) and other Inborn Errors of Metabolism."

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.

Gene Therapy
Most gene therapy is not covered. Molina covers limited gene therapy services in accordance with our medical policies, subject to Prior Authorization.

Hair Loss or Growth Treatment
Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered.

Infertility Services
Services related to the diagnosis and treatment of infertility, other than Medically Necessary iatrogenic fertility preservation services.

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. 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 Autism Spectrum Disorder (ASD) 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.

Male Contraceptives
Condoms for male use are not covered, as excluded under the Affordable Care Act.

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 Agreement.

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

Routine Foot Care Items and Services
Routine foot care items and services that are not Medically Necessary, except for persons diagnosed with 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
Covered Services do not include services performed by people who are not required by the state to hold licenses or certificates to provide those health care services.

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. Molina covers all Medically Necessary basic health services for complications for a non-Covered Service. For example, if You have a non-covered bariatric surgery or 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 (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to "Subrogation for a Surrogacy Arrangement" in the "Miscellaneous Provisions" section of this Agreement for information about Your obligations to Us in connection with a Surrogacy Arrangement, including Your obligations to reimburse Us for any Covered Services We cover and Your obligation to provide information to Us about anyone who may be financially responsible for the Covered Services the baby (or babies) receive.

Sexual Dysfunction

Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications are not covered unless required by state law.

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) 858-2150. TTY users may dial 711.

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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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 (888) 466-2219, 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 Agreement. 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 Covered Services

Any change to this Agreement, including, but not limited to, changes in Premiums, 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. Molina shall not change Deductible, Copayment, Coinsurance or Annual Out-of-Pocket Maximum amounts during the plan year, except when required by state or federal law.

When Will My Molina Healthcare Membership End? (Termination of Covered Services)
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, 2017, Your last minute of coverage was at 11:59 p.m. on June 30, 2017). 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.

- 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 twenty-six (26), Coverage under this Agreement, for a Dependent Child, will terminate at 11:59 p.m. on the last day of the calendar year in which the Dependent Child reaches the limiting age of twenty-six (26); unless the child has a disability and meets specified criteria. See the section titled "Age Limit for Children with Disabilities."

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 Agreement, 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 Agreement 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 that 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 twenty-four (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 in the individual market, in which case Molina Healthcare will provide You with written notice at least one-hundred-eighty (180) calendar days prior to the date the coverage will be discontinued.

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

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 Covered Services 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 Covered Services will terminate on his or her 19th birthday, without affecting the remainder of this Agreement.

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 California or Molina 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 (3) 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 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 (888) 466-2219.

Reinstatement after Termination
If permitted by the Covered California, We will allow reinstatement of Your Agreement (without a break in coverage) provided the reinstatement is a correction of an erroneous termination or cancellation action.

Re-enrollment After Termination for Non-Payment
If You are terminated for non-payment of premium and wish to re-enroll with Molina (during Open Enrollment or a Special Enrollment Period) in the following plan year, We may require that You pay any past due premium payments, plus Your first month's premium payment in full, before We will accept Your enrollment to become effective with Molina.

YOUR RIGHTS AND RESPONSIBILITIES

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

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 PCP).

- 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.
- 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 wrongdoing.
- 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 Us 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. TTY users may dial 711. 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 Agreement.

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 "Schedule of Benefits" at the front of this Agreement 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 Services 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 drug that was approved or does not require approval, Molina Healthcare will pay You back. You must submit Your claim for reimbursement within twelve (12) months from the date you made the payment.

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. You should also include the name of the Member for whom You are submitting the claim and Your policy number. If the bill is for a prescription drug, You will need to include a copy of the prescription drug label. Mail this information to the following address:

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

After we receive Your request for reimbursement, We will respond to You within thirty (30) calendar days. If Your claim is accepted, We will mail You a check. If Your claim is denied, 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) 858-2150, Monday through Friday, 8:00 a.m. to 6:00 p.m.

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 Us 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 (888) 858-2150.

COMPLAINTS AND APPEALS

What is a Complaint or Grievance?
A complaint is a grievance. A grievance is a written or oral expression of dissatisfaction that You have with Molina and/or any Participating Provider including quality of care concerns, and shall include a complaint, dispute, request for consideration or appeal made by You or Your representative. For example, You may be dissatisfied with the hours of availability of Your doctor. Issues relating to the denial of health care services are Appeals, and should be filed with Molina or the California State Department of Managed Health Care in the manner described below.

What if I Have a Complaint or Grievance?
If You have a problem with any Molina Healthcare services including Pediatric Dental Services, We want to help fix it.

The plan representative who may be contacted about the grievance is called the "Appeals and Grievance Coordinator" and may be contacted as follows:

- Call Molina Healthcare toll-free at 1 (888) 858-2150, Monday through Friday, 8:00 a.m. - 6:00 p.m.. TTY users may dial 711.

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

  Molina Healthcare
  Appeals and Grievance Coordinator
  200 Oceangate, Suite 100
  Long Beach, California 90802
  MolinaMarketplace.com

- You can also file a grievance by sending an email to: MHCMemberGandA@molinahealthcare.com or faxing 1 (562) 499-0757.

- 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.

Your coverage will remain in effect pending the outcome of Your internal appeal.

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.

Nonformulary External Exception Review
If You disagree with the denial of a "nonformulary drug" and/or step therapy exception request You, Your representative, or Your provider can file a grievance requesting an external exception review information as to how to request a review will also be included in the enrollee's notice of denial. Please refer to section titled "Complaints and Appeals" for information on how to file a grievance. The external exception review process is in addition to the right of the member to file a grievance or request independent medical review. Molina will respond to the external review request within:

- Twenty-four (24) hours following receipt of request for Exigent
- Seventy-two (72) hours following receipt of request for non-urgent

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) 858-2150, 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. TTY users may dial 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.

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 Covered Services 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 Covered Services 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 and/or gender identity.

If You think You have not been treated fairly please call the Customer Support Center toll-free at 1 (888) 858-2150.

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 reporting any change in address by contacting Covered California and or Molina Healthcare at 1 (800) 300-1506.

Subrogation for a Surrogacy Arrangement

If You enter into a Surrogacy Arrangement and You or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, You must reimburse Us for Covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy Arrangements" section does not affect Your obligation or pay Your Copayment or Coinsurance for these Covered Services. After You surrender a baby to the legal parents, You are not obligated to reimburse for any Covered Services that the baby receives (the legal parents are financially responsible for any Covered Services that the baby receives).

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the Surrogacy Arrangement, regardless of whether those payment are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, You must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Covered Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Covered Services that the baby (or babies) receive

- A signed copy of any contracts and other documents explaining the arrangement
- Any other information We request in order to satisfy Our rights

You must send this information to:

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

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights We may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce Our rights under this "Surrogacy Arrangements" section without Our prior, written consent.

If Your estate, parent, guardian or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator shall be subject to Our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign Our rights to enforce Our liens and other rights.

If You have questions about Your obligations under this provision, please contact Our Customer Support Center.

Wellness Program
Your Agreement includes access to a health activity program. The goal of the program is to encourage You to complete a health activity that supports Your overall health. The program is voluntary and available at no additional cost to You. The health activity we encourage You to complete is described below. For more information, please contact the Customer Support phone number on your ID Card.

Annual Health Activity
We encourage You to complete the annual health activity below during the calendar year. Upon completion, Molina may work with You to support Your overall wellness.

Annual Wellness Exam

- Provides You with the opportunity to obtain either an annual comprehensive physical exam through Your PCP, or an in-home health assessment exam facilitated through Molina

HEALTH MANAGEMENT LEVEL 1 PROGRAMS

If You are living with a chronic health illness or behavioral health illness, Molina Healthcare has programs that can help. You can be enrolled into a program(s) if You have certain health conditions and meet the requirements. It is Your choice to be enrolled in a program, and You can ask to be removed from a program at any time. Our programs include:

- Breathe with Ease Program (Asthma Management)
- Building Brighter Days Program (Adult Depression Management)
- Pregnancy Program

Your provider may refer You for a program(s) or You may self-refer, by calling the Health Management Department directly at 1 (866) 891-2320.

Health Management Level I - Health Education Programs

Weight Management Program

Our Weight Management Program is designed to help adults manage their weight. As part of the program, You will learn about healthy eating and exercise.

To learn more or to enroll, call Our Health Education Department at 1 (866) 472-9483.

Tobacco Cessation Program
Our Smoking Cessation Program is designed for adults who are eighteen (18) years of age or older upon enrollment in the program.

To learn more or to enroll, call Our Health Education Department at 1 (866) 472-9483.

Newsletters
Newsletters are posted on the www.MolinaHealthcare.com website at least 2 times a year. The articles are about topics asked by members like you. The tips can help you and your family stay healthy.

Health Education Materials
Our easy-to-read materials are about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes and other topics. To get these materials, ask Your doctor or visit Our website at: www.MolinaMarketplace.com/healthmanagement

Diabetes Prevention Program
Molina's Diabetes Prevention Program (DPP) is a CDC-recognized lifestyle change program. The DPP was developed to prevent type 2 diabetes. It is designed for Molina Members who have prediabetes or are at risk for type 2 diabetes. The DPP is not for Members who already have diabetes or who are currently pregnant.

Trained coaches lead the program to help You change certain aspects of Your lifestyle. They will show You how to eat healthier, reduce stress, and get more physical activity. The program also includes group support from others who share Your goals and struggles. This lifestyle change program is not a fad diet or an exercise class. It's not a quick fix. It's a year-long program focused on long-term changes and lasting results.

A year might sound like a long time, but learning new habits, gaining new skills, and building confidence takes time. As You begin to eat better and become more active, You will notice changes. The changes may be in how You feel or even in how You look. The DPP staff will work with You to see if You are ready to enroll in the program.

To qualify for the program, Members should meet all of the following requirements:

- Be at least 18 years old
- Be overweight
- Not have type 1 or type 2 diabetes
- Have a blood test result in the prediabetes range within the past 12 months; **OR** have been diagnosed with gestational diabetes in the past (not pregnant now).

Members can access Molina's Diabetes Prevention Program by visiting Your provider or by calling Member Services at 1 (888) 858-2150 (Monday-Friday, 8:00 a.m.-6:00 p.m.).

YOUR HEALTHCARE QUICK REFERENCE GUIDE

Department/Program	Type of help needed	Number to call/ Contact information
Molina Healthcare Customer Support Center	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 8:00 a.m. to 6:00 p.m.. When in doubt, call Us first.	1 (888) 858-2150 TTY users may dial 711.
Molina Healthcare Health Management Level 1 Programs	To request help managing a diagnosed health condition, including, asthma, depression or pregnancy. Hours: 4:00 a.m. and 8:00 p.m. (PT) Monday through Friday.	1 (866) 891-2320 TTY users may dial 711.
Molina Healthcare Health Education	To request information on smoking cessation and weight management. Hours: 6:00 a.m. and 6:00 p.m. (PT) Monday through Friday	1 (866) 472-9483 TTY users may dial 711.
Molina Healthcare 24-Hour Nurse Advice Line	If You have questions or concerns about Your or Your family's health. The Nurse Advice Line is staffed by registered nurses. Available 24 hours per day and 7 days per week.	English: 1 (888) 275-8750 Spanish: 1 (866) 648-3537 TTY users may dial 711.
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: (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: 1 (877) 486-2048 www.Medicare.gov
California Department of Managed Health Care (DMHC)	The DMHC 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 DMHC.	1 (888) HMO-2219 (1-888-466-2219) or TDD: 1 (877) 688-9891 **www.hmohelp.ca.gov**

ADDENDUM FOR 2020
PEDIATRIC DENTAL SERVICES

To be provided by California Dental Network, Inc.

200 Oceangate, Suite 100
Long Beach, CA 90802

California Dental Network
A DentaQuest company

DEFINITIONS

"Emergency Dental Care" means service required for immediate alleviation of acute symptoms associated with an emergency dental condition.

"Emergency Medical Condition" means a medical condition that includes severe pain or bleeding associated with dental problems, and/or unforeseen dental conditions which, if not immediately diagnosed and treated, may lead to disability, dysfunction or death manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably expected to result in any of the following:.

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

"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.

"Pediatric Essential Health Benefits" are one of the ten Essential Health Benefits required under the Affordable Care Act (ACA). Pediatric essential health benefits cover dental care and services such as cleanings, x-rays, and fillings for those up to age 19.

"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.

"Urgent Dental Care" means care required to prevent serious deterioration in a Member's health, following the onset of an unforeseen condition. Urgent care is care required within 24 to 72 hours, and includes only services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed.

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 1-855-424-8106 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.

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 1-855-424-8106 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 and urgent dental care is covered 24 hours a day, seven days a week, for all Members. Emergency dental Care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is care required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefits is the relief of acute symptoms only (for example: severe pain or bleeding) and does not include completed restoration. Please contact your Participating Dentist for emergency or urgent dental care. If your Dental Provider is not available during normal business hours, call Dental Customer Support at 1-855-424-8106.

In the case of an after-hours emergency, and your selected dental provider is unavailable, you may obtain emergency or urgent service from any licensed dentist. You need only submit to CDN, at the address listed herein, the bill incurred as a result of the dental emergency, evidence of payment and a brief explanation of the unavailability of your Provider. A non-covered parent of a covered child may submit a claim for emergency or urgent care without the approval of the covered parent, in such case the non-covered parent will be reimbursed. Upon verification of your Provider's unavailability, CDN will reimburse you for the cost of emergency or urgent services, less any applicable copayment.

Enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when you have an emergency medical condition that requires an emergency response.

What do I do if I am out of the area?

You are covered for emergency and urgent dental care. If you are away from your assigned participating provider, you may contact CDN for referral to another contracted dentist that can treat your urgent or emergency condition. If you are out of the area, it is after CDN's normal business hours, or you cannot contact CDN to redirect you to another contracted dentist, contact any licensed dentist to receive emergency or urgent care. You are required to submit a detailed statement from the treating dentist with a list of all the services provided. Member claims must be filed within 60 days and we will reimburse Members within 30 days for any emergency or urgent care expenses. 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.
23291 Mill Creek Dr. Ste. 100
Laguna Hills, CA 92653

Emergency dental care is recognized as dental treatment for the immediate relief of an emergency medical condition and covers only those dental services required to alleviate symptoms of such conditions. Urgent care is treatment required within 24 to 72 hours, and are services needed to prevent the serious deterioration of your dental health resulting from an unforeseen illness or injury for which treatment cannot be delayed. The Plan provides coverage for emergency or urgent dental services only if the services are required to alleviate symptoms such as severe pain or bleeding, or if a member reasonably believes that the condition, if not diagnosed or treated, may lead to disability, impairment, or dysfunction. The covered benefit is the relief of acute symptoms only, (for example: severe pain or bleeding) and does not include completed restoration.

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 1-855-424-8106. 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 from CDN, you will be responsible for the specialist's fee for any services rendered.

LIABILITY OF MEMBER FOR PAYMENT

By statute, every contract between CDN and a Participating Dentist shall provide that in the event that CDN fails to pay the Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by CDN.
In the event that CDN does not pay non-contracting Participating Dentists, the Member may be liable to the non-contracting Participating Dentist for costs of services rendered.

Members will be responsible for all supplementary charges, including copayments, deductibles and procedures not covered as Plan Benefits.

COMPLAINTS AND APPEALS

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

COORDINATION OF BENEFITS

In the event a member is covered under another plan or policy which provides coverage, benefits or services (plan) that are covered benefits under this dental plan, then the benefits of this plan shall be coordinated with the other plan according to regulations on "Coordination of Benefits". Covered California's standard benefit design requires the primary dental benefit payer is a health plan purchased through Covered California which includes pediatric dental essential health benefits. Any standalone dental plan offering the pediatric dental essential health benefit whether as a separate benefit or combined with a family dental benefit, covers benefits as a secondary dental benefit plan payer. The primary dental benefit payer is this health plan purchased through Covered California and includes pediatric dental essential health benefits.

A copy of the Coordination of Benefits regulations may be obtained from CDN.
The Plan and/or its treating providers reserve the right to recover the cost or value, as set forth in Section 3040 of the Civil Code, of covered services provided to a Member that resulted from or were caused by third parties who are subsequently determined to be responsible for the injury to the Member.

SECOND OPINION POLICY

It is the policy of CDN that a second opinion obtained from a participating panel provider will be a covered benefit. The covered benefit will need an approval from the Plan. A second opinion is encouraged as a positive component of quality of care.

General Practice Second Opinion
A request for a second opinion may be processed if one or more of the following conditions are evident:

- Member wishes affirmation of a complex or extensive treatment plan, alternative treatment plan, or clarification of a treatment plan or procedure.
- Member has a question about correctness of a diagnosis of a procedure or treatment plan.
- Member questions progress and successful outcome of a treatment plan.
- Plan requires a second opinion as part of the resolution of a Member's grievance.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to a CDN Dental Director for consideration.
Members may obtain a second opinion by contacting CDN at 1-855-424-8106. The Member will be given the names of providers in their area to select a second opinion provider. If the Member opts not to accept one of the contracted providers and wishes to go out of the network, it is not a covered benefit. The provider of choice will be notified by the Plan of the Member's need for a second opinion and the applicable co-payment. The Member will be responsible for obtaining an appointment from the second opinion provider.

The Plan representative will complete a second opinion form. X-rays and records from the current provider will be obtained, and along with the form, be sent to the second opinion provider.

Contracting providers have agreed in their contract to participate in the Quality Assurance activities of the Plan. The provision of a second opinion is considered to be part of the Plan's Quality Assurance Activities, therefore all contracting providers agree to:

- Provide copies of necessary records and radiographs to the Plan (at no charge to the Members, Plan or second opinion provider) for review by the second opinion provider.

- To agree to provide second opinion evaluation to Members at copayment upon approval of the second opinion request by the Plan, and to make the results of their evaluation available to the referring provider, the Member, and the Plan.

Second opinion providers may elect to accept a Member seeking a transfer but are not obligated to do so. Transfers must be mutually agreed to the second opinion provider and the Member seeking the second opinion.

Specialty Second Opinion

Specialty procedures incorporated in a treatment plan may require a specialty second opinion. These would be processed in the same manner as a general practice second opinion with the same guidelines.

Orthodontic Second Opinion

In the case of an Orthodontic second opinion, it will be processed the same as a general except, the following conditions must be evident:

- Questions about extractions of teeth to effect completion of treatment versus non-extraction of teeth.
- Questions on length of time of treatment.
- Questions about facial changes, growth and development.
- Questions about initiation of treatment, interceptive treatment, removable versus fixed therapy.
- Questions about multiple providers treating case vs. one provider reporting outcomes.

When a Member has a request for a second opinion that does not fall within the description outlines, the request will be forwarded to the Dental Director for consideration.

Denials

Conditions under which a second opinion may be denied:

- Member is not eligible or the Plan has been terminated.
- Member has completed treatment. Any second thoughts at this point are deemed a grievance.
- Member has consented to treatment. Dissatisfaction with the provider due to attitude or other personality discomforts (other than treatment plan).
- Treatment plan has been accepted by patient, treatment in progress and patient is not fulfilling agreements financially, appointments, follow-up, home care, etc.

Emergency Second Opinion

When a Member's condition is such that the Member faces imminent and serious threat to his or her health (including, but not limited to, potential loss of life, limb, or other body function), the request for a second opinion will be authorized within 72 hours of the Plan's receipt of the request, whenever possible.

CONTINUATION OF COVERAGE: ACUTE CONDITION OR SERIOUS CHRONIC CONDITION

At the request of the enrollee, the Plan will, under certain circumstances, arrange for continuation of covered services rendered by a terminated Participating Dentist to an enrollee who is undergoing a course

of treatment from a terminated Participating Dentist for an acute condition or serious chronic condition. In the event the enrollee and the terminated Participating Dentist qualify, the Plan will furnish the dental services on a timely and appropriate basis for up to 90-days or longer if necessary, for a safe transfer to another Participating Dentist as determined by the Plan in consultation with the terminated Participating Dentist, consistent with good professional practice.

The payment of copayments, deductibles, or other cost sharing components by the enrollee during the period of continuation of care with a terminated Participating Dentist shall be the same copayments, deductibles, or other cost sharing components that would be paid by the enrollee when receiving care from a Participating Dentist currently contracted with or employed by the Plan. The Plan will not cover services or provide benefits that are not otherwise covered under the terms and condition of the Plan contract.

For the purpose of this section:

"Terminated Participating Dentist" means a Participating Dentist whose contract to provide services to Plan enrollees is terminated or not renewed by the plan or one of the plan's contracting Participating Dentist groups. A terminated Participating Dentist is not a Participating Dentist who voluntarily leaves the plan or contracted Participating Dentist group.

"Acute Condition" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or medical problem that requires prompt medical attention and that has a limited duration.

"Serious Chronic Condition" means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature, and that does either of the following:

(a) Persists with full cure or worsens over an extended period of time.
(b) Requires ongoing treatment to maintain remission or prevent deterioration.

To request consideration of the continuance of services from a terminated Participating Dentist because you have an acute or serious chronic condition, call or write the Plan.

TIMELY ACCESS TO CARE & INTERPRETER SERVICES

CDN is required to provide or arrange for the provision of covered dental care services in a timely manner appropriate for the nature of the enrollee's condition, consistent with good professional practice. CDN ensures that enrollees are able to access clinically appropriate care in a timely manner. Urgent appointments within the CDN contracted provider network are available within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice. Non-urgent (routine) appointments are available within 36 business days of the request for appointment. Preventive dental care appointments are available within 40 business days of the request for appointment.
Interpreter services (as required by Section 1300.67.04 of Title 28) will be coordinated with scheduled appointments for health care services in a manner that ensures the provision of interpreter services at the time of the appointment. To arrange for interpreter services at your dental appointment, please contact the CDN member services department.

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.

Coverage of the pediatric dental essential health benefits is limited to children up to age 19.

Benefits and Limits for Diagnostic Services:

- Periodic oral evaluation (D0120): once every six months, per provider.
- Limited oral evaluation, problem focused (D0140): once per patient per provider.
- Comprehensive oral evaluation (D0150): once per patient per provider for the initial evaluation.
- Detailed and extensive oral evaluation (D0160): problem focused, by repot, once per patient per provider.
- Re-evaluation, limited, problem focused (not post-operative visit) (D0170) : a benefit for the ongoing symptomatic care of temporomandibular joint dysfunction; up to six times in a three month period, up to a maximum of 12 in a 12 month period.
- Radiographs (X-rays), Intraoral, complete series (including bitewings) (D0210): once per provider every 36 months.
- Radiographs (X-rays), Intraoral, periapical first film (D0220): a benefit to a maximum of 20 periapicals in a 12 month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, periapical each additional film (D0230): a benefit to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230).
- Radiographs (X-rays), Intraoral, occlusal film (D0240): A benefit up to a maximum of two in a six-month period per provider.
- Radiographs (X-rays), Extraoral (D0250): A benefit once per date of service.
- Radiographs (X-rays), bitewing , single film (D0270): A benefit once per date of service.
- Radiographs (X-rays), bitewings, two films (D0272): A benefit once every six months per provider.
- Radiographs (X-rays), bitewings, four films (D0274): A benefit once every six months per provider.
- Radiographs (X-rays) Temporomandibular joint arthrogram, including injection (D0320): A benefit for the survey of trauma or pathology; for a maximum of three per date of service.
- Radiographs (X-rays) Tomographic survey (D0322): A benefit twice in a 12 month period per provider.
- Radiographs (X-rays) Panoramic film (D0330): A benefit once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
- Radiographs (X-rays), Cephalometric radiographic image (D0340): A benefit twice in a 12 month period per provider.
- Oral/Facial Photographic Images 1st (D0350): A benefit up to a maximum of four per date of service.
- Diagnostic casts (D0470): A benefit once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment, for patients under the age of 21, for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

Benefits and Limits for Preventive Services:

- Prophylaxis, child (D1120): A benefit once in a six- month period for patients under the age of 21.

- Topical fluoride varnish (D1206): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride (D1208), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride (D1208).
- Topical application of fluoride (D1208): A benefit once in a six month period for patients under the age of 21. Frequency limitations shall apply toward topical application of fluoride varnish (D1206), once in a 12 month period for patients age 21 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).
- Sealant, per tooth (D1351): A benefit, for first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Preventive resin restoration in a moderate to high caries risk patient, permanent tooth (D1352): A benefit for first, second and third permanent molars that occupy the second molar position; only for an active cavitated lesion in a pit or fissure that does not cross the DEJ; for patients under the age of 21; once per tooth every 36 months per provider regardless of surfaces sealed.
- Space maintainer, fixed, unilateral (D1510): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral, maxillary (D1516): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, fixed, bilateral, mandibular (D1517): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires. Space maintainer, removable, unilateral (D1520): A benefit once per quadrant per patient; for patients under the age of 18; only to maintain the space for a single tooth. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; or for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires
- Space maintainer, removable, bilateral, maxillary (D1526): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
- Space maintainer, removable, bilateral, mandibular (D1527): A benefit once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant; for patients under the age of 18. Not a benefit when the permanent tooth is near eruption or is missing; for upper and lower anterior teeth; for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
-
- Re-cementation of space maintainer (D1550): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.

Benefits and Limits for Restorative Services:

- Primary teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 12 month period.

- Permanent teeth, amalgam restorations: one surface (D2140), two surfaces (D2150), three surfaces (D2160), four or more surfaces (D2161): A benefit once in a 36 month period.
- Primary teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 12 month period, each unique tooth surface is only payable once per tooth per date of service.
- Permanent teeth, resin based composite restorations (anterior): one surface (D2330), two surfaces (D2331), three surfaces (D2332), four or more surfaces or involving incisal angle (D2335): A benefit once in a 36 month period, each unique tooth surface is only payable once per tooth per date of service
- Primary teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 12 month period.
- Permanent teeth, resin based composite crown (anterior) (D2390): At least four surfaces shall be involved-a benefit once in a 36 month period
- Primary teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 12 month period.
- Permanent teeth, resin based composite restorations (posterior): one surface (D2391), two surfaces (D2392), three surfaces (D2393), four or more surfaces (D2394): A benefit once in a 36 month period.
- Crown, resin based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2710): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 resin-based composite (indirect), permanent anterior and posterior teeth, age 13 or older, (D2712): A benefit once in a five-year period; for any resin based composite crown that is indirectly fabricated. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; or for use as a temporary crown.
- Crown, resin with predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2721): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain/ceramic substrate, permanent anterior and posterior teeth, age 13 or older, (D2740): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, porcelain fused to predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2751): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2781): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Crown, 3/4 porcelain/ceramic, permanent anterior and posterior teeth, age 13 or older, (D2783): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd

molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

- Crown, full cast predominantly base metal, permanent anterior and posterior teeth, age 13 or older, (D2791): A benefit once in a five-year period. Not a benefit for patients under the age of 13; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
- Recement inlay, onlay or partial coverage restoration (2910): A benefit once in a 12 month period, per provider.
- Recement crown (D2920): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Prefabricated porcelain/ceramic crown - primary tooth (D2929): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - primary tooth (D2930): A benefit once in a 12 month period.
- Prefabricated stainless steel crown - permanent tooth (D2931): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Primary teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 12 month period.
- Permanent teeth, prefabricated resin crown (D2932), prefabricated stainless steel crown with resin window (D2933): A benefit once in a 36 month period. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
- Protective restoration (D2940): A benefit once per tooth in a six-month period, per provider. Not a benefit when performed on the same date of service with a permanent restoration or crown, for same tooth; on root canal treated teeth.
- Pin retention - per tooth, in addition to restoration (D2951): A benefit for permanent teeth only; when billed with an amalgam or composite restoration on the same date of service; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp; or for an anterior restoration when extensive coronal destruction involves the incisal angle.
- Post and core in addition to crown, indirectly fabricated (D2952): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Prefabricated post and core in addition to crown (D2954): A benefit once per tooth regardless of number of posts placed; only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
- Crown repair necessitated by restorative material failure (D2980): A benefit for laboratory processed crowns on permanent teeth. Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

Benefits and Limits for Endodontic Services:

- Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament (D3220): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; for a primary tooth with a necrotic pulp or a periapical lesion; for a primary tooth that is non-restorable; or for a permanent tooth.
- Pulpal debridement, primary and permanent teeth (D3221): A benefit for permanent teeth or for over-retained primary teeth with no permanent successor; once per tooth.
- Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development (D3222): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

- Pulpal therapy (resorbable filling) – anterior, primary tooth (D3230), or posterior, primary tooth (D3240), (excluding final restoration): A benefit once per primary tooth. Not a benefit for a primary tooth near exfoliation; with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; or with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
- Root canal therapy, anterior tooth (D3310), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
- Root canal therapy, bicuspid tooth (D3320), (excluding final restoration): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid (D3347).
- Root canal therapy, molar (excluding final restoration) (D3330): A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-molar (D3348). Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Retreatment of previous root canal therapy – anterior (D3346), bicuspid (D3347): Not a benefit to the original provider within 12 months of initial treatment.
- Retreatment of previous root canal therapy – molar (D3348): Not a benefit to the original provider within 12 months of initial treatment; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests
- Apexification/ recalcification/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection etc.) (D3351): A benefit once per permanent tooth. Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apexification/recalcification – interim (D3352): A benefit once per permanent tooth; only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351). Not a benefit for primary teeth; for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apicoectomy/periradicular surgery – anterior (D3410): A benefit for permanent anterior teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - bicuspid (first root) (D3421): A benefit for permanent bicuspid teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.
- Apicoectomy/periradicular surgery - molar (first root) (D3425): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider within 24 months of a prior apicoectomy/ periradicular surgery; same root; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
- Apicoectomy / periradicular surgery - molar, each additional root (D3426): A benefit for permanent 1st and second molar teeth only. Not a benefit to the original provider within 90 days of root canal therapy except when a medical necessity is documented; to the original provider

within 24 months of a prior apicoectomy/ periradicular surgery; or for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

Benefits and Limits for Periodontic Services:

- Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant (D4210) or one to three contiguous teeth, or tooth bounded spaces per quadrant (D4211): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closure)- four or more contiguous teeth or tooth bounded spaces per quadrant (D4260): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant (D4261): A benefit for patients age 13 or older; each once per quadrant every 36 months.
- Periodontal scaling and root planing - four or more teeth per quadrant (D4341) or one to three teeth per quadrant (D4342): A benefit for patients age 13 or older; each once per quadrant every 24 months.
- Periodontal maintenance (D4910): A benefit only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); only when preceded by a periodontal scaling and root planing (D4341- D4342); only after completion of all necessary scaling and root planings; once in a calendar quarter; only in the 24 month period following the last scaling and root planing.
- Unscheduled dressing change (by someone other than treating dentist) (D4920): for patients age 13 or older; once per patient per provider; within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261)

Benefits and Limits for Prosthodontic Services:

- Prosthodontic services provided solely for cosmetic purposes are not a benefit.
- Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.
- Spare or backup dentures are not a benefit.
- Evaluation of a denture on a maintenance basis is not a benefit.
- Complete denture – upper (D5110), lower (D5120): Each a benefit once in a five year period from a previous complete, immediate or overdenture- complete denture.
- Immediate denture – upper (D5130), lower (D5140): Each a benefit once per patient. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
- Partial denture - resin based with conventional clasps, rests and teeth, upper (D5211) or lower (D5212): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.
- Partial denture - cast metal resin based with conventional clasps, rests and teeth, upper (D5213) or lower (D5214): Each a benefit once in a five- year period; when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows: five posterior permanent teeth are missing, (excluding 3rd molars), or all four 1st and 2nd permanent molars are missing, or the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. Not a benefit for replacing missing 3rd molars.

- Adjust complete denture - upper (D5410) or lower (D5411): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit: same date of service or within six months of the date of service of a complete denture- maxillary (D5110) mandibular (D5120), immediate denture- maxillary (D5130) mandibular (D5140) or overdenture-maxillary (D5863) or mandibular (D5865); same date of service or within six months of the date of service of a reline complete denture (chairside) maxillary (D5730) mandibular (D5731), reline complete denture (laboratory) maxillary (D5750) mandibular (D5751) and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair broken complete denture base (D5511 OR D5512) and replace missing or broken teeth-complete denture (D5520).
- Adjust partial denture – upper (D5421), lower (D5422): A benefit once per date of service per provider; twice in a 12-month period per provider. Not a benefit same date of service or within six months of the date of service of: a partial- resin base maxillary (D5211) mandibular (D5212) or partial denture- cast metal framework with resin denture bases maxillary (D5213) mandibular (D5214); same date of service or within six months of the date of service of a reline partial denture (chairside) maxillary (D5740) mandibular (D5741), reline partial denture (laboratory) maxillary (D5760) mandibular (D5761), and tissue conditioning, maxillary (D5850) mandibular (D5851); same date of service or within six months of the date of service of repair resin denture base (D5611 OR D5612), repair cast framework (D5621 OR D5622), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).
- Repair broken complete denture base--lower(D5511) or upper (D5512): A benefit once per arch, per date of service per provider; twice in a 12-month period per provider. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
- Replace missing or broken teeth - complete denture (each tooth) (D5520): A benefit up to a maximum of four, per arch, per date of service per provider; twice per arch, in a12- month period per provider.
- Repair resin denture base—lower (D5611) or upper (D5612): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider; for partial dentures only. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
- Repair cast framework—lower (D5621) or upper (D5622): A benefit once per arch, per date of service per provider; twice per arch, in a 12-month period per provider.
- Repair or replace broken clasp (D5630): A benefit up to a maximum of three, per date of service per provider; twice per arch, in a 12- month period per provider.
- Replace broken teeth - per tooth (D5640): A benefit: up to a maximum of four, per arch, per date of service per provider; twice per arch, in a 12- month period per provider; for partial dentures only.
- Add tooth to existing partial denture (D5650): A benefit: for up to a maximum of three, per date of service per provider; once per tooth. Not a benefit for adding 3rd molars.
- Add clasp to existing partial denture (D5660): A benefit: for up to a maximum of three, per date of service per provider; twice per arch, in a 12-month period per provider.
- Reline complete denture (chairside) upper (D5730): a benefit once in a 12-month period; six months after the date of service for an immediate denture- maxillary (D5130)) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863)

that did not require extractions. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).

- Reline complete denture (chairside) lower (D5731): Each a benefit once in a 12-month period; six months after the date of service for an immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
- Reline partial denture (chairside) upper (D5740): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that required extractions, or 12 months after the date of service for partial denture- resin base maxillary (D5211) or partial denture- cast metal framework with resin denture bases maxillary (D5213) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) maxillary (D5760).
- Reline partial denture (chairside) lower (D5741): A benefit once in a 12-month period; six months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that required extractions, or 12 months after the date of service for partial denture- resin base mandibular (D5212) or partial denture- cast metal framework with resin denture bases mandibular (D5214) that did not require extractions. Not a benefit within 12 months of a reline partial denture (laboratory) mandibular (D5761).
- Reline complete denture (laboratory) upper (D5750): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- maxillary (D5130) or immediate overdenture- maxillary (D5863) that required extractions, or 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture (remote)- maxillary (D5863) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) maxillary (D5730).
- Reline complete denture (laboratory) lower (D5751): Each a benefit once in a 12-month period; six months after the date of service for a immediate denture- mandibular (D5140) or immediate overdenture- mandibular (D5865) that required extractions, or 12 months after the date of service for a complete (remote) denture- mandibular (D5120) or overdenture (remote)- mandibular (D5865) that did not require extractions. Not a benefit within 12 months of a reline complete denture (chairside) mandibular (D5731).
- Reline upper partial denture (laboratory) (D5760): A benefit: once in a 12-month period; six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions. Not a benefit within 12 months of a reline maxillary partial denture (chairside) (D5740); for a maxillary partial denture- resin base (D5211).
- Reline lower partial denture (laboratory) (D5761): A benefit once in a 12-month period; six months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions, or 12 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that did not require extractions. Not a benefit within 12 months of a reline mandibular partial denture (chairside) (D5741); for a mandibular partial denture- resin base (D5212).
- Tissue conditioning, upper (D5850): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory)

(D5750) and reline maxillary partial denture (laboratory) (D5760); or same date of service as a prosthesis that did not require extractions.

- Tissue conditioning, lower (D5851): A benefit twice per prosthesis in a 36-month period. Not a benefit same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761), or same date of service as a prosthesis that did not require extractions.
- Overdenture-axillary (D5863): A benefit once in a five- year period.
- Overdenture-mandibular (D5865): A benefit once in a five- year period.
-

Benefits and Limits for Maxillofacial Prosthetics

- Ocular prosthesis (D5916): Not a benefit on the same date of service as ocular prosthesis, interim (D5923).
- Ocular prosthesis, interim (D5923): Not a benefit on the same date of service with an ocular prosthesis (D5916).
- Obturator prosthesis, surgical (D5931): Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936)
- Obturator prosthesis, definitive (D5932): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, modification (D5933): A benefit twice in a 12 month period. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
- Obturator prosthesis, interim (D5936): Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).
- Feeding aid (D5951): A benefit for patients under the age of 18.
- Speech aid prosthesis, pediatric (D5952): A benefit for patients under the age of 18.
- Speech aid prosthesis, adult (D5953): A benefit for patients under the age of 18.
- D5955 Palatal lift prosthesis, definitive (D5955): Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).
- Palatal lift prosthesis, interim (D5958): Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
- Palatal lift prosthesis, modification (D5959): A benefit twice in a 12 month period. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).
- Speech aid prosthesis, modification (D5960): A benefit twice in a 12 month period. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).
- Fluoride gel carrier (D5986): A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

Benefits and Limits for Implant Services

- Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the California Dental Network for medical necessity for prior authorization. Exceptional medical conditions include, but are not limited to:
    - cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
    - severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

    - skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
    - traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
- Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.
- Single tooth implants are not a benefit of the California Dental Network Children's Dental HMO.
- Surgical placement of implant body: endosteal implant (D6010): Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.
- Surgical placement: eposteal implant (D6040): See D6010
- Surgical placement: transosteal implant (D6050): See D6010
- Connecting bar - implant supported or abutment supported (D6055): See D6010
- Prefabricated abutment - includes modification and placement (D6056): See D6010
- Custom fabricated abutment - includes placement (D6057): See D6010
- Abutment supported porcelain/ceramic crown (D6058): See D6010
- Abutment supported porcelain fused to metal crown (high noble metal) (D6059): See D6010
- Abutment supported porcelain fused to metal crown (predominantly base metal) (D6060): See D6010
- Abutment supported porcelain fused to metal crown (noble metal) (D6061): See D6010
- Abutment supported cast metal crown (high noble metal) (D6062): See D6010
- Abutment supported cast metal crown (predominantly base metal) (D6063): See D6010
- Abutment supported cast metal crown (noble metal) (D6064): See D6010
- Implant supported porcelain/ceramic crown (D6065): See D6010
- Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal) (D6066): See D6010
- Implant supported metal crown (titanium, titanium alloy, high noble metal) (D6067): See D6010
- Abutment supported retainer for porcelain/ceramic FPD (D6068): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (high noble metal) (D6069): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) (D6070): See D6010
- Abutment supported retainer for porcelain fused to metal FPD (noble metal) (D6071): See D6010
- Abutment supported retainer for cast metal FPD (high noble metal) (D6072): See D6010
- Abutment supported retainer for cast metal FPD (predominantly base metal) (D6073): See D6010
- Abutment supported retainer for cast metal FPD (noble metal) (D6074): See D6010
- Implant supported retainer for ceramic FPD (D6075): See D6010
- Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal) (D6076): See D6010
- Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal) (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment (D6091): See D6010

- Recement implant/abutment supported crown (D6092): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Recement implant/abutment supported fixed partial denture (D6093): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Abutment supported crown (titanium) (D6094): See D6010
- Repair implant abutment, by report (D6095): See D6010

Benefits and Limits for Fixed Prosthodontic Services:

- Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.
- Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.
- Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.
- Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.
- Pontic - cast predominantly base metal (D6211): A benefit: once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain fused to predominantly base metal (D6241): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - porcelain/ceramic (D6245): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Pontic - resin with predominantly base metal (D6251): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a benefit for patients under the age of 13.
- Crown - resin with predominantly base metal (D6721): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain/ceramic (D6740): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - porcelain fused to predominantly base metal (D6751): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 cast predominantly base metal (D6781): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Crown - 3/4 porcelain/ceramic (D6783): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.

- Crown - full cast predominantly base metal (D6791): A benefit once in a five year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a benefit for patients under the age of 13.
- Recement bridge (D6930): Not a benefit within 12 months of a previous re- cementation by the same provider.
- Fixed partial denture repair necessitated by restorative material failure (D6980): Not a benefit within 12 months of initial placement or previous repair, same provider.

Benefits and Limits for Oral Surgery Services

- Extraction, coronal remnants - deciduous tooth (D7111): Not a benefit for asymptomatic teeth.
- Extraction, erupted tooth or exposed root (elevation and/or forceps removal) (D7140): Not a benefit to the same provider who performed the initial tooth extraction.
- Surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated (D7210): A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
- Removal of impacted tooth - soft tissue (D7220): A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
- Removal of impacted tooth - partially bony (D7230): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
- Removal of impacted tooth - completely bony (D7240): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.
- Removal of impacted tooth - complete bony with unusual surgical complications (D7241): A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
- Surgical removal of residual tooth roots (cutting procedure) (D7250): A benefit when the root is completely covered by alveolar bone. Not a benefit to the same provider who performed the initial tooth extraction.
- Oral Antral Fistula Closure (D7260): A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity. Not a benefit in conjunction with extraction procedures (D7111 – D7250).
- Primary closure of a sinus perforation (D7261): A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.
- Tooth reimplantation and/ or stabilization of accidentally evulsed or displaced tooth (D7270): A benefit once per arch regardless of the number of teeth involved, and for permanent anterior teeth only.
- Surgical access of an unerupted tooth (D7280): Not a benefit for 3rd molars.
- Placement of device to facilitate eruption of impacted tooth (D7283): A benefit only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Biopsy of oral tissue - hard (bone, tooth) (D7285): A benefit for the removal of the specimen only; once per arch, per date of service regardless of the areas involved. Not a benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

- Biopsy of oral tissue – soft (D7286): A benefit for the removal of the specimen only; up to a maximum of three per date of service. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
- Surgical repositioning of teeth (D7290): A benefit for permanent teeth only; once per arch; only for patients in active orthodontic treatment. Not a benefit for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
- Transseptal fiberotomy/supra crestal fiberotomy, by report (D7291): A benefit once per arch; only for patients in active orthodontic treatment.
- Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7310): Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.
- Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant (D7320): A benefit regardless of the number of teeth or tooth spaces. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.
- Vestibuloplasty – ridge extension (secondary epithelialization) (D7340): A benefit once in a five year period per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch; on the same date of service with extractions (D7111-D7250) same arch.
- Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) (D7350): A benefit once per arch. Not a benefit on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; on the same date of service with extractions (D7111- D7250) same arch.

- Excision of benign lesion, complicated (D7412): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Excision of malignant lesion, complicated (D7415): A benefit when there is extensive undermining with advancement or rotational flap closure.
- Removal of lateral exostosis (maxilla or mandible) (D7471): A benefit once per quadrant; for the removal of buccal or facial exostosis only.
- Removal of Torus Palatinus (D7472): A benefit once in the patient's lifetime.
- Removal of torus mandibularis (D7473): A benefit once per quadrant.
- Surgical reduction of osseous tuberosity (D7485): A benefit once per quadrant.
- Incision and drainage of abscess - intraoral soft tissue (D7510): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Incision and drainage of abscess – intraoral soft tissue- complicated (includes drainage of multiple fascial spaces). (D7511): A benefit once per quadrant, same date of service. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
- Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue (D7530): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
- Removal of reaction producing foreign bodies, musculoskeletal system (D7540): A benefit once per date of service. Not a benefit when associated with the removal of a tumor, cyst (D7440-D7461) or tooth (D7111- D7250).
- Partial ostectomy /sequestrectomy for removal of non-vital bone (D7550): A benefit once per quadrant per date of service; only for the removal of loose or sloughed off dead bone caused by

infection or reduced blood supply. Not a benefit within 30 days of an associated extraction (D7111-D7250).

- Maxillary sinusotomy for removal of tooth fragment or foreign body (D7560): Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7680): A benefit for the treatment of simple fractures.
- Facial bones – complicated reduction with fixation and multiple surgical approaches (D7780): A benefit for the treatment of compound fractures.
- Occlusal orthotic device, by report (D7880): A benefit for diagnosed TMJ dysfunction. Not a benefit for the treatment of bruxism.
- Unspecified TMD therapy, by report (D7899): Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis
- Suture of recent small wounds up to 5 cm (D7910): Not a benefit for the closure of surgical incisions.
- Complicated suture – up to 5 cm (D7911): Not a benefit for the closure of surgical incisions.
- Complicated suture – greater than 5 cm (D7912): Not a benefit for the closure of surgical incisions.
- Skin graft (identify defect covered, location and type of graft) (D7920): Not a benefit for periodontal grafting.
- Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report (D7950): Not a benefit for periodontal grafting.
- Sinus augmentation with bone or bone substitutes via a lateral open approach (D7951): A benefit only for patients with authorized implant services.
- Sinus augmentation with bone or bone substitute via a vertical approach (D7952): A benefit only for patients with authorized implant services.
- Repair of maxillofacial soft and/or hard tissue defect (D7955): Not a benefit for periodontal grafting.
- Frenulectomy – also known as frenectomy or frenotomy – separate procedure (D7960): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Frenuloplasty (D7963): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Excision of hyperplastic tissue - per arch (D7970): A benefit once per arch per date of service. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
- Surgical reduction of fibrous tuberosity (D7972): A benefit once per quadrant per date of service.
- Appliance removal (not by dentist who placed appliance), includes removal of archbar (D7997): A benefit once per arch per date of service; for the removal of appliances related to surgical procedures only. Not a benefit for the removal of orthodontic appliances and space maintainers.

Benefits and Limits for Orthodontic Services

- Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 21 and shall be prior authorized.
- Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification

Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

- The automatic qualifying conditions are:
    - cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
    - a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    - a crossbite of individual anterior teeth causing destruction of soft tissue,
    - an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    - a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
- Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion (D8080): A benefit for handicapping malocclusion, cleft palate and facial growth management cases; for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per patient per phase of treatment.
- Removable appliance therapy (D8210): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Fixed appliance therapy (D8220): A benefit for patients ages 6 through 12; once per patient. Not a benefit for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires; for space maintainers in the upper or lower anterior region.
- Pre-orthodontic treatment visit (D8660): A benefit prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required; once every three months; for patients under the age of 21; for a maximum of six.
- Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion (D8670): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per calendar quarter.
- The maximum quantity of monthly treatment visits for the following phases are:
- Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Cleft Palate:
        - Primary dentition– up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
        - Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or
    - Facial Growth Management:
        - Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

    - Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
    - Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
- Orthodontic retention (removal of appliances, construction and placement of retainer(s)) (D8680): A benefit for patients under the age of 21; for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly); once per arch for each authorized phase of orthodontic treatment.
- Repair of orthodontic appliance (D8691): A benefit for patients under the age of 21; once per appliance. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
- Replacement of lost or broken retainer (D8692): A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention (D8680).
- Rebonding or recementing: and/or repair, as required, of fixed retainers (D8693): A benefit for patients under the age of 21; once per provider.

Benefits and Limits for Adjunctive Services

- Palliative (emergency) treatment of dental pain - minor procedure (D9110): A benefit once per date of service per provider regardless of the number of teeth and/or areas treated. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Fixed partial denture sectioning (D9120): A benefit when at least one of the abutment teeth is to be retained.
- Local anesthesia not in conjunction with outpatient surgical procedures (D9210): A benefit once per date of service per provider; only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
- Deep sedation/general anesthesia - each 15 minute increment (D9223): Not a benefit on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Analgesia nitrous oxide (D9230): A benefit for uncooperative patients under the age of 13, or for patients age 13, or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non-intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia – first 15 minutes (D9239): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment (D9239 OR D9243): Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.

- Non-intravenous conscious sedation (D9248): A benefit for uncooperative patients under the age of 13, or for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration; once per date of service. Not a benefit on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9239 OR D9243); when all associated procedures on the same date of service by the same provider are denied.
- House/Extended care facility call (D9410): A benefit once per patient per date of service; only in conjunction with procedures that are payable.
- Hospital or ambulatory surgical center call (D9420): A benefit for each hour or fraction thereof as documented on the operative report. Not a benefit: for an assistant surgeon; for time spent compiling the patient history, writing reports or for post- operative or follow up visits.
- Office visit for observation (during regularly scheduled hours) - no other services performed (D9430): A benefit once per date of service per provider. Not a benefit when procedures other than necessary radiographs and/or photographs are provided on the same date of service; for visits to patients residing in a house/ extended care facility.
- Office visit - after regularly scheduled hours (D9440): A benefit once per date of service per provider; only with treatment that is a benefit.
- Therapeutic parenteral drug, single administration (D9610): A benefit for up to a maximum of four injections per date of service. Not a benefit for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9239 OR D9243) or non- intravenous conscious sedation (D9248); when all associated procedures on the same date of service by the same provider are denied.
- Application of desensitizing medicament (D9910): A benefit once in a 12-month period per provider; for permanent teeth only. Not a benefit when used as a base, liner or adhesive under a restoration; the same date of service as fluoride (D1206 and D1208).
- Treatment of complications (post-surgical) - unusual circumstances, by report (D9930): A benefit once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; for the removal of bony fragments within 30 days of the date of service of an extraction. Not a benefit for the removal of bony fragments on the same date of service as an extraction; for routine post- operative visits.
- Occlusion analysis – mounted case (D9950): A benefit once in a 12-month period; for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition. Not a benefit for bruxism only.
- Occlusal adjustment – limited (D9951): A benefit once in a 12-month period per quadrant per provider; for patients age 13 or older; for natural teeth only. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.
  Occlusal adjustment – complete (D9952): A benefit once in a 12-month period following occlusion analysis- mounted case (D9950); for patients age 13 or older; for diagnosed TMJ dysfunction only; for permanent dentition.

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.

INDEPENDENT MEDICAL REVIEW

External independent review is available to members for review of denials of experimental therapies where such therapies might be indicated for treatment of a life threatening condition or seriously debilitating illness or for denials based on service not being medically necessary by contacting Member Services within five business days of the denial. The request for an independent medical review will be reviewed by the Dental Director or, if necessary, referred to the Quality Assurance Committee. Timeframes for considering independent medical review requests will be the same as for grievance processing. Members have the right to file information in support of the request for independent medical review.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (1-855-424-8106) 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 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**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS		
	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. Members should keep receipts for all dental work to show out-of-pocket costs.	

	Individual Child	**Family (2 or more children)**
Deductible	None	None
Office Copay	No Charge	No Charge
Waiting Period	None	None
Annual Benefit Limit	None	None

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**
D0120	periodic oral evaluation	No Charge
D0140	limited oral evaluation	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	comprehensive oral evaluation	No Charge
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (not post-operative visit)	No Charge
D0171	Re-evaluation – post-operative office visit	No Charge
D0180	Comprehensive periodontal evaluation	No Charge
D0210	intraoral - complete series (including bitewings) - limited to 1 series every 36 months	No Charge
D0220	intraoral - periapical first film	No Charge
D0230	intraoral - periapical each additional film	No Charge
D0240	intraoral - occlusal film	No Charge
D0250	Extraoral - first film	No Charge
D0251	Extra-oral posterior dental radiographic image	No Charge
D0270	bitewing - single film	No Charge
D0272	bitewings - two films	No Charge
D0273	Bitewings - three films	No Charge
D0274	bitewings - four films - limited to 1 series every 6 months	No Charge

D0277	Vertical bitewings - 7 to 8 films	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge
D0322	Tomographic survey	No Charge
D0330	panoramic film	No Charge
D0340	Cephalometric radiographic image	No Charge
D0350	photograph 1st	No Charge
D0351	3D photographic image	No Charge
D0460	pulp vitality tests	No Charge
D0470	Diagnostic casts may be provided only if one of the above conditions is present	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge
D1110	Prophylaxis-Adult	No Charge
D1120	prophylaxis - child	No Charge
D1206	topical fluoride varnish	No Charge
D1208	topical application of fluoride	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	oral hygiene instructions	No Charge
D1351	sealant - per tooth	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1353	Sealant repair – per tooth	No Charge
D1354	Interim caries arresting medicament application – per tooth	No Charge
D1510	space maintainer - fixed - unilateral	No Charge
D1516	space maintainer - fixed – bilateral, maxillary	No Charge
D1517	space maintainer - fixed – bilateral, mandibular	No Charge
D1520	Space maintainer-removable – unilateral	No Charge
D1526	space maintainer - removable – bilateral, maxillary	No Charge
D1527	space maintainer - removable – bilateral, mandibular	No Charge
D1550	Re-cementation of space maintainer	No Charge
D1555	Removal of fixed space maintainer	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral	No Charge
D2140	amalgam - one surface permanent or primary	$25
D2150	amalgam - two surfaces permanent or primary	$30
D2160	amalgam - three surfaces permanent or primary	$40
D2161	amalgam - four or more surfaces permanent or primary	$45
D2330	resin-based composite - one surface, anterior	$30
D2331	resin-based composite - two surfaces, anterior	$45
D2332	resin-based composite - three surfaces, anterior	$55
D2335	resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60
D2390	Resin based composite crown, anterior	$50
D2391	Resin based composite - one surface, posterior	$30

D2392	Resin based composite - two surfaces, posterior	$40
D2393	Resin based composite - three surfaces, posterior	$50
D2394	Resin based composite - four or more surfaces, posterior	$70
D2710	crown - resin-based composite laboratory	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190
D2721	Crown - resin with predominantly base metal	$300
D2740	crown - porcelain/ceramic substrate	$300
D2751	crown - porcelain fused to predominantly base metal	$300
D2781	crown - 3/4 cast predominantly base metal	$300
D2783	Crown – 3/4 porcelain/ceramic	$310
D2791	crown - full cast predominantly base metal	$300
D2910	Recement inlay, onlay or partial coverage restoration	$25
D2915	Recement cast or prefabricated post and core	$25
D2920	recement crown	$25
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95
D2930	prefabricated stainless steel crown - primary tooth	$65
D2931	prefabricated stainless steel crown - permanent tooth	$75
D2932	Prefabricated resin crown	$75
D2933	Prefabricated stainless steel crown with resin window	$80
D2940	protective restoration	$25
D2941	Interim therapeutic restoration – primary dentition	$30
D2949	Restorative foundation for an indirect restoration	$45
D2950	Core buildup, including any pins	$20
D2951	pin retention - per tooth, in addition to restoration	$25
D2952	post and core in addition to crown, indirectly fabricated	$100
D2953	Each additional indirectly fabricated post, same tooth	$30
D2954	prefabricated post and core in addition to crown	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post - same tooth	$35
D2971	Additional procedures to construct new crown under existing partial denture framework	$35
D2980	crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
D3110	pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap (indirect) excluding final restoration	$25
D3220	therapeutic pulpotomy (excluding final restoration)	$40
D3221	Pulpal debridement, primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55
D3310	root canal therapy, anterior tooth (excluding final restoration)	$195
D3320	root canal therapy, bicuspid tooth (excluding final restoration)	$235
D3330	root canal therapy, molar (excluding final restoration)	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50

D3333	Internal root repair of perforation defects	$80
D3346	retreatment of previous root canal therapy - anterior	$240
D3347	retreatment of previous root canal therapy - bicuspid	$295
D3348	retreatment of previous root canal therapy - molar	$365
D3351	apexification/recalcification – initial visit	$85
D3352	apexification/recalcification - interim	$45
D3410	apicoectomy/periradicular surgery - anterior	$240
D3421	apicoectomy/periradicular surgery - bicuspid (first root)	$250
D3425	apicoectomy/periradicular surgery - molar (first root)	$275
D3426	Apioectomy / periradicular surgery - molar, each additional root	$110
D3427	Periradicular surgery without apicoectomy	$160
D3430	retrograde filling - per root	$90
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
D4210	gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	$50
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – muco - gingival surgery per quadrant	$265
D4261	Osseous surgery (including flap entry and closures) - one to three contiguous teeth or tooth bounded spaces - per quadrant	$140
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	Not Covered
D4341	periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	periodontal scaling and root planing - one to three teeth per quadrant	$30
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	$220
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15
D4999	Unspecified periodontal procedure, by report	$350
D5110	complete denture – maxillary	$300
D5120	complete denture – mandibular	$300
D5130	immediate denture - maxillary	$300
D5140	immediate denture - mandibular	$300
D5211	maxillary partial denture - resin based with conventional clasps, rests and teeth	$300
D5212	mandibular partial denture - resin based with conventional clasps, rests and teeth	$300
D5213	maxillary partial denture - cast metal resin based with conventional clasps, rests and teeth	$335
D5214	mandibular partial denture - cast metal resin based with conventional clasps, rests and teeth	$335
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	$275

D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	$275
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$330
D5410	adjust complete denture - maxillary	$20
D5411	adjust complete denture – mandibular	$20
D5421	adjust partial denture – maxillary	$20
D5422	adjust partial denture – mandibular	$20
D5511	repair broken complete denture base-mandibular	$40
D5512	repair broken complete denture base-maxillary	$40
D5520	replace missing or broken teeth - complete denture (each tooth)	$40
D5611	repair resin denture base-mandibular	$40
D5612	repair resin denture base-maxillary	$40
D5621	repair cast framework-mandibular	$40
D5622	repair cast framework--maxillary	$40
D5630	repair or replace broken clasp	$50
D5640	replace broken teeth - per tooth	$35
D5650	add tooth to existing partial denture	$35
D5660	add clasp to existing partial denture	$60
D5730	reline complete maxillary denture (chairside)	$60
D5731	reline complete mandibular denture (chairside)	$60
D5740	reline maxillary partial denture (chairside)	$60
D5741	reline mandibular partial denture (chairside)	$60
D5750	reline complete maxillary denture (laboratory)	$90
D5751	reline complete mandibular denture (laboratory)	$90
D5760	reline maxillary partial denture (laboratory)	$80
D5761	reline mandibular partial denture (laboratory)	$80
D5850	tissue conditioning, maxillary	$30
D5851	tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture-complete maxillary	$300
D5864	Overdenture-partial maxillary	$300
D5865	Overdenture-complete mandibular	$300
D5866	Overdenture-partial mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350

D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification	$145
D5960	Speech aid prosthesis, modification	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Topical Medicament Carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Second stage implant surgery	$350
D6013	Surgical placement of mini implan	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$350
D6052	Semi-precision attachment abutment	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300

D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30
D6085	Provisional implant crown	$300
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6096	Remove broken implant retaining screw	$60
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partially edentulous arch – maxillary	$350
D6113	Implant/abutment supported removable denture for partially edentulous arch – mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partially edentulous arch – maxillary	$350
D6117	Implant/abutment supported fixed denture for partially edentulous arch – mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
D6211	pontic - cast predominantly base metal	$300
D6241	pontic - porcelain fused to predominantly base metal	$300
D6245	Pontic - porcelain/ceramic	$300

D6251	pontic - resin with predominantly base metal	$300
D6721	crown - resin with predominantly base metal	$300
D6740	crown - porcelain/ceramic	$300
D6751	crown - porcelain fused to predominantly base metal	$300
D6781	crown - 3/4 cast predominantly base metal	$300
D6783	crown - 3/4 porcelain/ceramic	$300
D6791	crown - full cast predominantly base metal	$300
D6930	recement bridge	$40
D6980	fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
D7111	Extraction, coronal remnants - deciduous tooth	$40
D7140	extraction, erupted tooth or exposed root	$65
D7210	surgical removal of erupted tooth requiring elevation of flap and removal of bone and/or sectioning of tooth	$120
D7220	removal of impacted tooth - soft tissue	$95
D7230	removal of impacted tooth - partially bony	$145
D7240	removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - complete bony with unusual surgical complications	$175
D7250	surgical removal of residual tooth roots requiring cutting of soft tissue and bone and removal of tooth structure and closure.	$80
D7260	Oral Antral Fistula Closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	tooth reimplantation / stabilization	$185
D7280	Surgical access of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	biopsy of oral tissue - hard (bone, tooth)	$180
D7286	biopsy of oral tissue – soft	$110
D7290	Surgical repositioning of teeth	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80
D7310	alveoloplasty in conjunction with extractions – per quadrant	$85
D7311	alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50
D7320	alveoloplasty not in conjunction with extractions – per quadrant	$120
D7321	alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350
D7410	excision of benign lesion up to 1.25 cm	$75
D7411	excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180

D7451	removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330
D7460	removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible)	$140
D7472	Removal of Torus Palatinus	$145
D7473	Removal of torus mandibularis	$140
D7485	Surgical reduction of osseous tuberosity	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	incision and drainage of abscess - intraoral soft tissue	$70
D7511	Incision & drainage of abscess - intraoral soft tissue - complicated	$70
D7520	incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140
D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350

D7860	Arthrostomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350
D7875	Arthroscopy – surgical: synovectomy	$350
D7876	Arthroscopy – surgical: discectomy	$350
D7877	Arthroscopy – surgical: debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7881	Occlusal orthotic device adjustment	$30
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130
D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	frenulectomy – also known as frenectomy or frenotomy – separate procedure	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue - per arch	$175
D7971	Excision of pericoronal gingival	$80
D7972	Surgical reduction of fibrous tuberosity	$100
D7979	Non-surgical Sialolithotomy	$155
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60

D7999	Unspecified oral surgery procedure, by report	$350
D8080	Comprehensive orthodontic treatment of the adolescent dentition Handicapping malocclusion	$1,000
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract) Handicapping malocclusion	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	
D9110	palliative (emergency) treatment of dental pain - minor procedure	$30
D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	local anesthesia	$15
D9222	Deep sedation/general anesthesia - first 15 minutes	$45
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45
D9230	analgesia nitrous oxide	$15
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes	$60
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$60
D9248	non-intravenous conscious sedation	$65
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50
D9311	Consultation with a medical health professional	No Charge
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	$20
D9440	office visit - after regularly scheduled hours	$45
D9610	Therapeutic parenteral drug, single administration	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament	$20
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35
D9943	Occlusal guard adjustment	Not Covered
D9950	Occlusion analysis – mounted case	$120
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$210
D9999	unspecified adjunctive procedure, by report	$0

Endnotes to 2020 Dental Standard Benefit Plan Designs
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
2) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
3) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
4) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
5) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.