Molina Healthcare of California

Marketplace

2023

Agreement and Combined Evidence of Coverage and Disclosure Form

Molina Bronze 60 HMO AI-AN

Molina Healthcare of California
200 Oceangate, Suite 100,
Long Beach, CA 90802

MHC01012023 CA23EOCE_B3

MOLINA REFERENCE GUIDE

Service	Need	Where to Go
Emergency Services	• Treatment of an Emergency Medical Condition	**Call 911**, or go to any Emergency room, even if it is a Non-Participating Provider or outside of the Service Area.

Getting Care	• Urgent Care
	  ○ Minor Illnesses
	  ○ Minor Injuries
	• Virtual Care
	• 24-hour advice on medical and mental health questions
		Call your Doctor
		
		Urgent Care Centers
		Find a Provider or Urgent Care center
		MolinaHealthcare.com/ProviderSearch
		
		Virtual Care
		www.teladoc.com/molinamarketplace
		1-800-TELADOC
		
		24-Hour Nurse Advice Line
		1 (888) 275-8750 (English)
		1 (866) 648-3537 (Spanish)

Online Access	• Find or change your doctor • View benefits and Member Handbook • View or print ID card • Track claims	**Go to** MyMolina.com **Download** the Molina Mobile App **Visit the Provider Directory** MolinaHealthcare.com/ProviderSearch
Plan Details	• Answers about your plan, programs, services, or prescription drugs • ID card support • Access to care • Prenatal care • Well-infant visits • Payment questions	**Molina Member Services Center** 1 (888) 858-2150 Monday through Friday, 8:00 a.m. to 6:00 p.m. **Go to** MyMolina.com **Go to** MolinaPayment.com
Eligibility & Enrollment	• Eligibility questions • Add a dependent • Report change of address or income	1 (800) 300-1506 **Go to** CoveredCA.com

Interpreter Services: Molina offers interpreter services for any Member who may need language assistance to understand and obtain health coverage under this Agreement. Molina provides these services at no additional cost to the Member. Molina will provide oral interpretation services and written translation services for any materials vital to a Member understanding their health care coverage. Members who are hearing- or speech-impaired can use the Telecommunications Relay Service by dialing 711

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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.

In general, a Member must receive Covered Services from a Participating Provider; otherwise, the services are not covered, the Member will be 100% responsible for payment to the Non-Participating Provider, and the payment will not apply to the Deductible or Annual Out-of-Pocket Maximum. However, a Member may receive Covered Services from a Non-Participating Provider for Emergency Services and for exceptions described in the section of the Agreement titled "Access to Care."

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	$8,200
Entire Family of 2 or more	$16,400

[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)		
Oral Exam, Preventive Cleaning, X-ray, Sealants, Fluoride Application Space Maintainers - Fixed	For a complete list of Cost Sharing, please refer to the Pediatric Dental Addendum attached to the Agreement.	
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 and a half 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

Policy Issuance: This Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form (also called the "Agreement") is issued by Molina Healthcare of California ("Molina,") 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 agrees to provide the Covered Services as outlined in this Agreement.

Incorporation by Reference: This Agreement, amendments and riders to this Agreement, the applicable Schedule of Benefits for this plan, and any application(s) submitted to the Marketplace and/or Molina to obtain coverage under this Agreement, including the applicable rate sheet for this product, are incorporated into this Agreement by reference, and constitute the entire legally binding contract between Molina and the Subscriber.

Contract Changes: No amendment, modification or other change to this entire legally binding contract between Molina and the Subscriber shall be valid until approved by Molina and evidenced by a written document signed by an executive officer of Molina. No agent of Molina has authority to change this Agreement and incorporated documents or to waive any of its provisions.

Time Zone: Except as otherwise expressly provided herein, all references to a specific time of day refer to the specific time of day in the Pacific time zone of the United States of America.

Confidential Communication Requests: A "Confidential Communication Request" is a request by a Member that Plan communications containing Medical Information be communicated to them at a specific mail or email address or specific telephone number, as designated by the Member. Members may request confidential communication in the form and format requested by the Member, if it is readily producible in the requested form and format, or at alternative locations. The Member's Confidential Communication Request must be in writing or by electronic transmission. Members may use Molina's Confidential Communication Request form to make Confidential Communication Requests. Please visit https://www.molinahealthcare.com/members or call Member Services at the toll-free number listed on the Molina Member ID Card, if interested in making a Confidential Communication Request. Molina will accommodate Confidential Communications Requests, which shall be valid until the Member submits a revocation of the Confidential Communication Request or a new Confidential Communication Request is submitted by the Member. The Confidential Communication Request shall apply to all communications that disclose Medical Information or Provider name and address related to receipt of medical services by the Member requesting the confidential communication.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

THANK YOU FOR CHOOSING MOLINA

As an organization that's been taking care of kids, adults and families for 40 years, Molina is excited to be your Plan.

We're providing this Agreement to tell you:

- How you can get services through Molina
    - Getting an interpreter
    - Choosing a Primary Care Provider (PCP)
    - Making an appointment
- The terms and conditions of coverage under this Agreement
- Benefits and coverage as a Molina Member
    - Checking on Prior Authorization status
- How to contact Molina

Please read this Agreement carefuly. Inside is information about a wide range of health needs and services provided. For questions or concerns, please reach out to Member Services at MolinaMarketplace.com or at the phone number on page 2 of this Agreement.

We look forward to serving you!

Molina Marketplace

DEFINITIONS

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

Affordable Care Act: The comprehensive health care reform law enacted in March 2010 (sometimes known as "ACA," "PPACA," or "Obamacare").

Allowed Amount: The maximum amount that Molina will pay for a Covered Service less any required Member Cost Sharing. As applicable:

1. *For Covered Services furnished by a Participating Provider:* These services shall be reimbursed at the contracted rate with the Participating Provider for such Covered Services.
2. *For certain Covered Services furnished by a Non-Participating Provider:* Subject to exceptions expressly permitted by law, the services described below shall be reimbursed at the out-of-network rate, as that term is defined and determined under applicable federal law:
    - Emergency Services furnished by a Non-Participating Provider
    - Post-Stabilization Services furnished by a Non-Participating Provider when such Covered Services are treated, for reimbursement purposes, as Emergency Services under applicable State Law or federal law
    - Air ambulance services furnished by a Non-Participating Provider; and
    - Covered Services furnished by a Non-Participating Provider during a visit at a Participating Provider that is a hospital, critical access hospital, ambulatory surgical center, or other facility required by law.

    In the case of exceptions expressly permitted by law, the Allowed Amount shall be determined in accordance with the procedures (including dispute resolution proceedings) or other requirements dictated by applicable state law, when federal law defers to state law in determining reimbursement amounts to Non-Participating Providers, or federal law, when federal law controls the reimbursement amount to Non-Participating Providers.
3. *For all other Covered Services furnished by a Non-Participating Provider in accordance with this Agreement:* Except if otherwise expressly required by applicable law, these services shall be reimbursed at the lowest of (a) Molina's median contracted rate for such Covered Service(s), (b) 100% of the published Medicare rate for such Covered Service(s), (c) Molina's usual and customary method for determining payment for such Covered Service(s), or (d) a negotiated amount agreed to by the Non-Participating Provider and Molina.

Annual Out-of-Pocket Maximum (also referred to as "OOPM"): The most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on Deductibles, Copayments, and Coinsurance, Molina pays 100% of the costs of Covered Services. Amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards 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 Dependent, when that person meets the individual OOPM amount; or
2. the family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount.

Once the total Cost Sharing for the Subscriber or a Dependent adds up to the individual OOPM amount, Molina will pay 100% of the charges for Covered Services for that individual for the rest of the calendar year if they remain enrolled in this Plan. Once the Cost Sharing for two or more Member's family adds up to the family OOPM amount, Molina will pay 100% of the charges for Covered Services for the rest of the calendar year for the Member and every Member of their family if they remain enrolled in this Plan.

Balance Bill or Balance Billing: When a Provider bills a Member for the difference between the Provider's charged amount and the Allowed Amount. A Molina Participating Provider may not balance bill a Member for Covered Services.

Child-Only Coverage: 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: A percentage of the charges for Covered Services the Member must pay when they receive certain Covered Services. The Coinsurance amount is calculated as a percentage of the rates that Molina has negotiated with the Participating Provider. If applicable, Coinsurances are listed in the Schedule of Benefits.

Copayment: A fixed amount the Member will pay for a Covered Service. If applicable, Copayments are listed in the Schedule of Benefits.

Cost Sharing: The share of costs that a Member will pay out of their own pocket for Covered Services. This term generally includes Deductibles, Coinsurance, and Copayments, but it doesn't include Premiums, Balance Bill amounts for non-network providers, or the cost of non-covered services.

Covered Service or Covered Services: Medically Necessary services, including some medical devices, equipment, and prescription drugs, that Members are eligible to receive from Molina under this Plan.

Deductible: The amount Members must pay for Covered Services before Molina begins to pay for Covered Services. Please refer to the Schedule of Benefits to see what Covered Services are subject to the Deductible and the Deductible amounts for the Member's Plan.

Dependent: A Member who meets the eligibility requirements as a Dependent, as described in this Agreement.

Distant Site: The site at which a physician or other licensed provider, delivering a professional service, is physically located at the time the service is provided through telemedicine.

Drug Formulary or Formulary: A list of drugs this Molina Plan covers. The Drug Formulary puts drugs in different Cost Sharing levels or tiers.

Durable Medical Equipment or DME: Equipment and supplies ordered by a Provider for everyday or extended use. DME may include Medically Necessary oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency or Emergency Medical Condition: An illness, injury, symptom (including severe pain), or condition severe enough that, in the absence of immediate medical attention, could reasonably be expected to result in: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) Serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Services: Services to evaluate, treat or stabilize an Emergency Medical Condition. These services may be provided in a licensed emergency room or other facility that provides treatment of Emergency Medical Conditions.

Essential Health Benefits or EHB: A standardized set of essential health benefits that are required to be offered by Molina to Members and/or their 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: 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.

FDA: The United States Food and Drug Administration.

Marketplace: A governmental agency or non-profit entity that meets the applicable standards of the Affordable Care Act and helps residents of the State buy qualified health plan coverage from companies or health plans such as Molina. The Marketplace in California is also known as Covered California.

Medical Information: Any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service

plan, pharmaceutical company, or contractor regarding a Patient's medical history, mental or physical condition, or treatment.

Medical Necessity or Medically Necessary: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Member: An individual who is eligible and enrolled under this Agreement, and for whom Molina has 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 Agreement but will not be a Member.

Molina Healthcare of California ("Molina"): The corporation authorized in California as a health maintenance organization and contracted with the Marketplace.

Molina Healthcare of California Agreement and Combined Evidence of Coverage and Disclosure Form: This document, which has information about coverage under this Plan. It is also called the "**Agreement**."

Non-Participating Provider: A Provider that has not entered into a contract with Molina to provide Covered Services to Members.

Other Practitioner: A Participating Provider who provides Covered Services to Members within the scope of their license but who is not a Primary Care Provider or Specialist.

Participating Provider: A Provider that furnishes any health care services and is licensed or otherwise authorized to furnish such services and contracts with Molina and has agreed to provide Covered Services to Members.

Patient: means a natural person, whether or not still living, who received health care services from a provider of health care and to whom Medical Information pertains.

Plan: Health insurance coverage issued to an individual and Dependents, if applicable, that provides benefits for Covered Services. Depending on the services, Member Cost Sharing may apply.

Post-Stabilization Services: Items and services that are furnished (regardless of the department of the hospital where that occurs) after the Member is stabilized and as part of out-patient observation or an inpatient or out-patient stay with respect to the visit in which Emergency Services are furnished.

Primary Care Provider or PCP: A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), Certified Nurse Practitioner, clinical nurse specialist, or Physician Assistant, as allowed under state law and the terms of the Plan, who provides, coordinates, or helps a Member access a range of health care services.

Prior Authorization: Approval from Molina that is needed before Members get a medical service or drug so that the service or drug is covered.

Provider: Any health professional, Hospital, other institution, organization, pharmacy, or person that furnishes any health care services and is licensed to furnish such services, except as otherwise covered by this Agreement, or whose services are deemed medically necessary for treatment of a mental health or substance use disorder.

Schedule of Benefits: A comprehensive listing of Covered Services with applicable Member Cost Sharing.

Service Area: The geographic area where Molina has been authorized by the State to market individual products sold through the Marketplace, enroll Members obtaining coverage through the Marketplace and provide benefits through approved individual health plans sold through the Marketplace.

Specialist: A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

State Law: The body of law in California. It consists of the state's constitution, statutes, regulations, sub-regulatory guidance, state regulatory agency directives and common law.

Urgent Care or Urgent Care Services: Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

ENROLLMENT AND ELIGIBILITY

An individual must be enrolled as a Member of this Plan for Covered Services to be available. To enroll and become a Member of this Plan, an individual must meet all eligibility requirements established by the Marketplace. An individual that satisfies the eligibility requirements, meets Premium payment requirements, and is enrolled by Molina is the Subscriber for this Plan.

Open Enrollment Period: The Marketplace will set yearly period when eligible individuals can submit an application and enroll in a health plan or change plans. The effective date of coverage will be January 1st or a date determined by the Marketplace.

Special Enrollment Period: If an individual does not enroll during an Open Enrollment Period, they may be able to enroll during a Special Enrollment Period. To qualify for a Special Enrollment Period, an individual must have experienced certain life changes established by the Marketplace. The effective date of a Member's coverage will be determined by the Marketplace. For more information about Open Enrollment and Special Enrollment Periods, please visit www.CoveredCA.com.

Child-Only Coverage: Molina offers Child-Only Coverage for individuals under the age of 21, and a parent or legal guardian applies on behalf of the child. For more information regarding eligibility and enrollment, please contact the Marketplace.

Dependents: Subscribers who enroll during the Open Enrollment Period established by the Marketplace may also apply to enroll individuals as eligible Dependents. Dependents must meet the eligibility requirements as established by the Marketplace. Dependents are subject to the terms and conditions of this Agreement. Molina does not limit Dependent eligibility based on financial dependency, residency, status as a student, employment, eligibility for other coverage, or marital status. A foster child is not eligible for enrollment as a Dependent. The following individuals are considered Dependents:

- **Spouse:** The individual lawfully married to the Subscriber under State Law.

- **Child or Children:** The Subscriber's son, daughter, adopted child, or stepchild. Each child is eligible to apply for enrollment as a Dependent until the age of 26.

- **Child with a Disability:** A child who reaches the age of 26 is eligible to continue to be a Dependent if the child meets the following eligibility criteria:
  - The child is incapable of self-sustaining employment because of a physically or mentally disabling injury, illness, or condition; and
  - The child is chiefly dependent upon the Subscriber for support and maintenance.

  A disabled child may remain covered by Molina as a Dependent for as long as he or she remains incapacitated and continues to meet the eligibility criteria described above.

- **Domestic Partner:** An individual of the same or opposite sex who lives together and shares a domestic life with the Subscriber but isn't married or joined by a civil union to the Subscriber. The Domestic Partner must meet any eligibility and verification of domestic partnership requirements established by the Marketplace and State Law.

- **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.

- **Subscriber's dependent parent or dependent stepparent:** Subscriber's dependent parents or stepparents who live or reside within the plan's service area qualify as Dependents in accordance with the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP).

Adding New Dependents: To enroll a Dependent who first becomes eligible to enroll after the Subscriber is enrolled (such as a new Spouse, a newborn child, or a newly adopted child), the Subscriber must contact the Marketplace and submit any required applications, forms and requested information for the Dependent. The request to enroll a new Dependent must be submitted to the Marketplace within 60 days from the date the Dependent became eligible to enroll in the Plan.

- **Spouse:** A Spouse may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
  - Loss of minimum essential coverage, as defined by the Affordable Care Act
  - The date of marriage to the Subscriber
  - The Spouse gains status as a citizen, national, or lawfully present individual
  - The Spouse permanently moves into the Service Area.

- **Children (Under 26 Years of Age):** Children may be added as a Dependent if the Subscriber applies no later than 60 days after any event listed below:
  - Loss of minimum essential coverage, as defined 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 gains status as a citizen, national, or lawfully present individual
  - The Child permanently moves into the Service Area.

- **Newborn Child:** A newborn child of a Subscriber is eligible as a Dependent at birth. A newborn is initially covered for 31 days, including the date of birth. A newborn child is eligible to continue enrollment if they enrolled within Molina within 60 days.

  Please note: Claims for newborns for eligible Covered Services will be processed as part of the mother's claims and any Deductible or OOPM amounts satisfied through the processing of such a newborn's claims will accrue as part of the mother's Deductible and OOPM. However, if an enrollment file is received for the newborn during the first 31 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 OOPM amounts satisfied through the processing of these claims will accrue as part of the newborn's individual Deductible or OOPM (i.e., not under the enrolled mother's Deductible and OOPM). A newborn's claim is a claim in which the newborn child is identified as the individual receiving services.

Discontinuation of Dependent Coverage: Coverage for Dependent will be discontinued:

- At 11:59 p.m. on the last day of the calendar year that the Dependent child attains age 26, unless the child has a disability and meets specified criteria (see "Child with a Disability").
- The date a final decree of divorce, annulment or dissolution of marriage is entered between the Dependent Spouse and Subscriber.
- The date a termination of the domestic partnership decree between the Subscriber and Domestic Partner is entered.
- For Child-Only Coverage, at 11:59 p.m. on the last day of the calendar year in which the non-Dependent Member reaches the limiting age of 21. Member and any Dependents may be eligible to enroll in other products offered by Molina through the Marketplace.
- Date the Subscriber loses coverage under this Plan.

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 a Member is no longer eligible for coverage under this Plan, Molina will send a written notification at least 10 calendar days before the effective date on which the Member will lose eligibility. The Member can appeal the loss of eligibility with the Marketplace.

PREMIUM PAYMENT

To begin and maintain coverage under this Plan, Molina requires Members to make monthly payments in consideration, known as Premium Payments or Premiums. Premium Payment for the upcoming coverage month is due no later than the date stated on the Premium bill (this is the "**Due Date**"). Molina will send a Subscriber written notification informing them of the amount due for coverage for the upcoming month in advance of the Due Date.

Advanced Premium Tax Credit (APTC): Advanced Premium Tax Credit is a tax credit a Subscriber can take in advance to lower their monthly Premium. Molina does not determine or provide tax credits, and Subscribers must contact the Marketplace to determine if they are eligible. If the Subscriber is eligible for an Advanced Premium Tax Credit, they can use any amount of the credit in advance to lower their Premium.

Payment: Molina accepts Premium Payments online, by phone, by mail, and through money order. Please refer to MolinaPayment.com or contact Member Services for further information. Premium Payments are not accepted at Molina office locations.

Late Payment Notice: If full payment of the Premium is not received on or before the Due Date, Molina will send a notice of start of grace period or, if the Subscriber is receiving advanced payment of tax credit, a notice of start of federal grace period to the Subscriber's address of record.

Grace Period: A Grace Period is a period of time after a Member's Premium Payment is due and has not been paid in full. If a Subscriber hasn't made full payment, they may do so during the Grace Period and avoid losing their coverage. The length of time for the Grace Period is determined by whether the Subscriber receives an APTC.

- **Grace Period for Subscribers with APTCs:** If a Subscriber receives an APTC, Molina will give the Subscriber and Dependents a 3-month grace period before cancelling or not renewing coverage due to failure to pay the Premium. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. Molina will pay for Covered Services received during the first month of the 3-month grace period. If the Subscriber does not pay the

Premium by the end of the first month of the 3-month grace period, coverage under this plan will be suspended and Molina will not pay for Covered Services after the first month of the grace period until Molina receives the delinquent Premiums. If all Premiums due and owing are not received by the end of the 3-month grace period, this Agreement will be cancelled effective the day after the last day of the first month of the grace period. Termination or nonrenewal of this Agreement for non-payment will be effective **as of 12:01 a.m.** of the day after the last day of the first month of the grace period.

- **Grace Period for Subscribers with No APTC:** If a Subscriber does not receive an APTC, Molina will give the Subscriber and Dependents a 30-calendar-day grace period before cancelling or not renewing coverage due to failure to pay the Premium. The Grace Period will begin the first day of the first month for which full Premium is not received by Molina. Molina will continue to provide coverage pursuant to the terms of this Agreement, including paying for Covered Services received during the 30-calendar-day grace period. If the Subscriber does not pay the Premium by the end of the grace period, this Agreement will be cancelled at the end of the grace period. The Subscriber will still be responsible for any unpaid Premium owed for the grace period. Termination or nonrenewal of this Agreement for non-payment will be effective **as of 11:59 p.m.** on the last day of the grace period.

Termination Notification for Non-Payment: Upon termination of this Agreement, Molina will mail a Notice of End of Coverage to the Subscriber's address of record specifying the date and time when the membership ended.

If you claim that Molina ended a Member's right to receive Covered Services because of the Member's health status, requirements for health care services, or nonpayment of premiums, you may request a review by the Department of Managed Health Care. To request a review, contact the Department at:

Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814

You may call the Department for more information on filing a grievance toll-free at 1 (888) 466-2219; TDD: 1 (877) 688-9891 for the hearing and speech impaired; FAX: 1 (916) 255-5241. The Department's internet website is www.dmhc.ca.gov.

Reinstatement after Termination: Molina will allow reinstatement of Members, without a break in coverage, provided the reinstatement is a correction of an erroneous termination or cancellation action and is permitted by the Marketplace.

Re-enrollment After Termination for Non-Payment: If a Subscriber is terminated for non-payment of Premium and enrolls with Molina during the Open Enrollment Period or a Special Enrollment Period for the following plan year, Molina may require that a Subscriber pay any past due Premiums. Molina will also require first month's Premium paid in full, before Molina accepts enrollment of the Subscriber. If a Subscriber pays all

past due Premiums, eligible claims that were previously denied as a result of that nonpayment will be reprocessed for payment.

Renewability of Coverage: Molina will renew coverage for Members on the first day of each month if all Premiums which are due have been received. Renewal is subject to Molina's right to amend this Agreement and the Member's continued eligibility for this Plan. Members must follow all procedures required by the Marketplace to redetermine eligibility and guaranteed renewability for enrollment every year during the Open Enrollment Period.

TERMINATION OF COVERAGE

The termination date is the first day a former Member is not enrolled with Molina. If a Member's coverage terminates for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the end-of-coverage date. Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on behalf of the terminated Member applicable to periods after the termination date, less any amounts due to Molina or its Providers for coverage of Covered Services provided prior to the date of Termination, will be refunded to the Subscriber within 30 calendar days. Molina and its Providers will not have any further liability or obligation under this Plan. In the case of fraud or intentional misrepresentation, Molina may retain portions of this amount in order to recover losses due to the fraud.

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) 466-2219, or TDD number for the hearing or speech impaired, toll-free, at 1 (877) 688-9891, or online at the Department's internet website www.dmhc.ca.gov.

Molina may terminate or non-renew a Member for any of the following reasons:

Dependent and Child-Only Ineligibility Due to Age: A Dependent no longer meets the eligibility requirements for coverage required by the Marketplace and Molina due to their age. Please refer to the "Discontinuation of Dependent Coverage" section of the "Enrollment and Eligibility" section for more information regarding when termination will be effective.

Member Ineligibility: A Member no longer meets the eligibility requirements for coverage required by the Marketplace and Molina. The Marketplace will send the Member notification of loss of eligibility. Molina will also send the Member written notification when informed that the Member no longer resides within the Service Area. Coverage will end at 11:59 p.m. on the last day of the month following the month in which either of these notices is sent to the Member. The Member may request an earlier termination effective date.

Non-Payment of Premium: Please refer to "Premium Payment" section

Fraud or Intentional Misrepresentation: If the Member has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material

fact in connection with coverage, Molina will send written notification of termination, and the Member's coverage will end at 11:59 p.m. on the 30th day from the date notification is sent. If the Member has committed Fraud or Intentional Misrepresentation, Molina may not accept enrollment from the Member in the future and may report any suspected criminal acts to authorities. After a Member's first 24 months of coverage, Molina may not terminate coverage due to any intentional omissions, misrepresentations, or inaccuracies on the application form.

Member Disenrollment Request: Members may submit disenrollment requests to the Marketplace. Membership will end at 11:59 p.m. on the 14th calendar day following the date of the request or a later date if requested by the Member. Molina may, at its discretion, accommodate a request to end membership in fewer than 14 calendar days.

Change Marketplace Health Plans: Member decides to change from Molina to another health plan offered through the Marketplace either (i) within the first 60 calendar days from the effective date of coverage if the Member is not satisfied with Molina, or (ii) during an annual open enrollment period or other special enrollment period for which Member has been determined eligible in accordance with the Marketplace's special enrollment procedures, or (iii) when the Member seeks to enroll a new Dependent. Membership will end at 11:59 p.m. on the day before the effective date of coverage through the Member's new health plan.

Discontinuation of a Particular Product: Molina decides to discontinue offering a product, in accordance with State Law. Molina will provide written notification of discontinuation at least 90 calendar days before the date the coverage will be discontinued.

Discontinuation of All Coverage: Molina elects to discontinue offering all health coverage in a State in accordance with State Law. Molina will send Members written notification of discontinuation at least 180 calendar days prior to the date the coverage will be discontinued.

ACCESS TO CARE

For an Emergency, call 911. For an Emergency, Members may call an ambulance or go to any Emergency facility, even if it is a Non-Participating Provider or outside of the Service Area.
24-Hour Nurse Advice Line: Registered Nurses are available 24 hours a day, 365 days a year to answer questions and help Members access care. The Nurse Advice Line phone number is shown on page 2 of this Agreement.

Participating Provider Requirement: In general, a Member must receive Covered Services from a Participating Provider; otherwise, the services are not covered, the Member will be 100% responsible for payment to the Non-Participating Provider, and the payments will not apply to the Member's Deductible or OOPM. However, a Member may receive Covered Services from a Non-Participating Provider for the following:

- Emergency Services
- Services from a Non-Participating Provider that are subject to Prior Authorization

- Exceptions described below under “Out-of-Area Urgent Care Services”
- Exceptions described below under “Non-Participating Provider at a Participating Provider Facility”
- Exceptions described below under “No Participating Provider to Provide a Covered Service”
- Exceptions described below under “Continuity of Care”
- Exceptions described below under “Transition of Care”
- Exceptions described below under “Second Opinions”

To locate a Participating Provider, please refer to the provider directory at MolinaMarketplace.com or call Member Services.

Member ID Card: Members should always carry their Member identification (ID) card. Members must show their ID card every time they receive Covered Services. For a replacement ID card, visit MyMolina.com or contact Member Services. Digital versions of the ID card are available through MyMolina.com and the Molina Mobile App.

Member Right to Obtain Health Care Services Outside of Policy: Molina does not restrict Members from freely contracting at any time to obtain any health care services outside this Agreement on any terms or conditions they may choose. However, Members will be 100% responsible for payment for such services and the payments for such services will not apply to their Deductible or OOPM for any of services under this Agreement. For exceptions, Members should review the “Covered Services” section of the Agreement.

Primary Care Provider (PCP): A Primary Care Provider (or PCP) takes care of routine and basic health care needs. PCPs provide Members with services such as physical exams, immunizations, or treatment for an illness or injury that is not needed on an urgent or Emergency basis. Molina asks Members to select a PCP from the Provider Directory. If a PCP is not selected, one will be assigned by Molina.
Members can request to change their PCP at any time at MyMolina.com or by contacting Member Services.

Each family member can select a different PCP. A doctor who specializes in pediatrics may be selected as a child’s PCP. A doctor who is an OB/GYN may be selected as a Member’s PCP with no referrals required.

Sometimes a Member may not be able to select the PCP they want. This may happen because:

- The PCP is no longer a Participating Provider with Molina.
- The PCP already has all the patients he or she can take care of right now.

Telehealth Services: Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. Covered Services are also available through Telehealth, except as specifically stated in this Agreement. Telehealth includes telepsychiatry. In-person contact with a Provider is not required for these services, and the type of setting

where these services are provided is not limited. The following additional provisions apply to the use of Telehealth services:

- Must be obtained from a Participating Provider
- Are meant to be used when care is needed now for non-Emergency medical issues
- Are a method of accessing Covered Services, and not a separate benefit
- Are not permitted when the Member and Participating Provider are in the same physical location
- Do not include texting, facsimile or email only
- Covered Services provided through store and forward technology must include an in-person office visit to determine diagnosis or treatment.

Molina covers services appropriately delivered through telehealth on the same basis and to the same extent that Molina covers the same service through in-person diagnosis, consultation, or treatment. Coverage is not limited only to services delivered by select third-party corporate telehealth providers. The services offered by a third-party corporate telehealth provider are also available through a Member's primary care provider or another Molina network provider in person or via telemedicine (if available). Members have a right to access their medical records pursuant to, and consistent with, California Health and Safety Code Chapter 1 (commencing with Section 123100) of Part 1 of Division 106. The record of any services provided to a Member through a third-party corporate telehealth provider shall be shared with the Member's primary care provider, unless the Member objects. Services received through a third-party corporate telehealth provider are available at no greater than in-network cost-sharing, and out-of-pocket costs, if any, shall accrue to any applicable deductible or out-of-pocket maximum.

Out-of-Area Urgent Care Services: While a Member is outside of the Service Area, the Member may receive Urgent Care Services from a Non-Participating Provider to prevent serious deterioration of health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area. For out-of-area Urgent Care Services, Members may go to the nearest emergency room.

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

No Participating Provider to Provide a Covered Service: If there is no Participating Provider that can provide a non-Emergency Medically Necessary Covered Service, Molina will provide the Covered Service through a Non-Participating Provider in the same manner as and at no greater cost than the Covered Services when rendered by a Participating Provider. Prior Authorization is required before the initiation of the service by a Non-Participating Provider.

Continuity of Care: If a Member is assigned to a PCP or hospital that is ending a contract with Molina, then Molina will provide the Member 60 calendar days advance written notice of such a contract ending between Molina and PCP or acute care hospital.

If a Member is undergoing treatment for one of the conditions listed below and the doctor or hospital providing treatment is no longer a Participating Provider with Molina, the Member may ask Molina's permission to stay with the doctor or hospital for continuity of care.

The following conditions may be eligible for continuity of care if the member has received treatment for the same condition within the past 12 months:

- A Member has 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.

  For a Serious Chronic Condition, a Member may be able to stay with the doctor or hospital for up to 12 months.
- A Member is pregnant. The Member may stay with the doctor or hospital for the length of the pregnancy. The length of the pregnancy includes the three trimesters of pregnancy and the immediate postpartum period.
- A Member presents written documentation of being diagnosed with a maternal mental health condition from the treating health care provider. "Maternal Mental Health Condition" means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery. If a Member has a Maternal Mental Health Condition, the Member may be able to stay with the doctor or hospital for up to 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- A Member has 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. The Member may stay with the doctor or hospital for the length of the acute condition.
- A Member's child is a newborn or child up to age 36 months. The Member's child may stay with the doctor or hospital for up to 12 months.
- A Member has a terminal illness. The Member may stay with the doctor or hospital for the length of the illness.
- A Member has received Prior Authorization for a surgery or other procedure to be performed within 180 calendar days of the date the doctor or hospital will no longer be with Molina.

Eligibility for continuity of care is not based strictly upon the name of the Member's condition.

The doctor or hospital might not agree to continue providing services or might not agree to comply with Molina's contractual terms and conditions that are imposed on Participating Providers. If that happens, Molina will assign the Member to a new doctor or send the Member to a new hospital for care.

To submit a request to stay with the same doctor or hospital for continuity of care, a Member should call Member Services.

If a Member is newly enrolled and the Member's prior coverage was terminated because the Member's 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 a Member's 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 the Member's coverage is effective with Molina.

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

For Inpatient Hospital Services: With the Member's assistance, Molina may reach out to any prior insurer (if applicable) to determine the 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 the prior insurer or the Member did not have coverage through an insurer at the time of admission, Molina would assume responsibility for Covered Services upon the effective date of the Member's coverage with Molina, not prior.

Second Opinions: A Member or PCP may want a second doctor to review the Member's condition. This can be a primary care provider or a Specialist. This new doctor looks the Member's medical record. The doctor may see the Member at their office. This doctor may suggest a plan of care. This is called a second opinion.

A Member's PCP can refer the Member to a Participating Provider for a second opinion. Members do not need permission from Molina to get a second opinion from a Participating Provider. If there is no provider in the network to give a second opinion, the Member may be able to get a second opinion from a Non-Participating Provider. If a Member asks for a second opinion from a Non-Participating Provider, Molina will review and let the Member know if the second opinion was approved.

Here are some reasons why a Member may want a second opinion:

- The Member's symptoms are complex or confusing.
- The first doctor is not sure the diagnosis is correct.
- The Member has followed a doctor's plan of care, and the Member's health has not improved.
- The Member is not sure if surgery is needed, or the Member thinks surgery is needed.
- The Member does not agree with what a doctor thinks is the problem.
- The Member does not agree with a doctor's plan of care.
- A doctor has not answered the Member's concerns about a diagnosis or plan of care.

- There may be other reasons.

The second doctor will write a report of what he or she finds. The Member and the Member's PCP will get a written report of the second opinion.

The Member may contact Member Services for help getting a second opinion.

Moral Objections: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at 1 (888) 858-2150 to ensure that you can obtain the health care services that you need.

Accessing Care for Members with Disabilities: The Americans with Disabilities Act (ADA) prohibits discrimination based on disability. The ADA requires Molina and its contractors to make reasonable accommodations for Members with disabilities. Members with disabilities should contact Member Services to request reasonable accommodation assistance

Physical Access: Every effort has been made to ensure that Molina's offices and the offices of Participating Providers are accessible to persons with disabilities. Member's with special needs should call Member Services at the number shown on page 2 of this Agreement for assistance finding an appropriate Participating Provider.

Access for the Speech- or Hearing-Impaired: Call Member Services at the TTY 711 number for assistance.

Access for Persons with Low Vision or Who Are Blind: This Agreement and other important product materials will be made available in accessible formats 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 Member Services.

Disability Access Grievances: If a Member believes Molina or its doctors have failed to respond to their disability access needs, the Member may file a grievance with Molina. Please refer to the "Appeals and Grievances" section of this Agreement for information regarding how to file a grievance.

Timely Access to Care: Doctor offices should provide 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)	within 48 hours
Urgent care appointments requiring Prior Authorization (including primary care or Specialist)	within 96 hours
Non-urgent appointments for primary care	within 10 business days
Non-urgent appointments with Specialist	within 15 business days
Non-urgent appointments with a non-physician mental health or substance use disorder care provider	within 10 business days
Non-urgent follow-up appointments with a nonphysician mental health care or substance use disorder provider	within 10 business days of the prior appointment
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 make an appointment, and Molina provides interpreter services at no cost, 24 hours per day. Just call Member Services.

PRIOR AUTHORIZATION

Molina must approve your use of some medical services and drugs before they will be covered. This approval is called Prior Authorization ("PA"). Members may receive many Covered Services without PA. If a medical service or drug needs PA, Member's Provider will seek PA for on their behalf.

Please view MolinaMarketplace.com/CAGetCare for a full list of Covered Services. The list shows which services do and do not need PA. Members may also call Customer Support.

Molina reviews a request for PA after receiving all needed information. Member's Provider may ask that Molina speed up the PA process if the request is urgent. Molina will tell the Member's Provider about the decision within the time allowed by State and Federal Law.

Members will be told if the request is denied. Members will get information about how to appeal the denial.

PA rules may change. Members should contact Customer Support or visit MolinaMarketplace.com/CAGetCare prior to receiving certain services.

PA Timeframes

Medical Services:

- **Routine PA Requests:**

    - Not to exceed 5 business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.
- **Urgent PA Requests:**
    - 72 hours from request.
    - The urgent timeframes apply if use of the standard timeframes:
        - May seriously threaten your life or health.
        - May seriously threaten your ability to regain full function.
        - Would cause severe pain and cannot be managed without the requested care, according to your provider.
- **Emergency Medical Conditions and Post-Stabilization Services:** Do not need PA.

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

Medical Necessity: Prior Authorization determinations are made based on a review of Medical Necessity for the requested service. Molina is here to help Members throughout this process. If a Member has questions about how a certain service may be approved, visit MolinaMarketplace.com or call Member Services. Molina can explain how this type of decision is made.

Medical Necessity determination criteria for coverage of healthcare services include whether services are appropriate to the Member's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration. Medical Necessity determinations are based on generally accepted medical or scientific evidence and are generally consistent with accepted practice parameters.

Molina will not approve a Prior Authorization if information requested in connection with reviewing the Prior Authorization is not provided. If a service request is not Medically Necessary, it will not be approved. If the service requested is not a Covered Service, it will not be approved. Members will receive written notification informing them why the Prior Authorization request was not approved. The Member, the Member's authorized representative or the Member's Provider may appeal the decision. The denial decision letter will inform Members of the process to appeal the denial decision. These instructions are also in the section of this Agreement titled "Appeals and Grievances."

If a Member or the Member's Provider decides to proceed with a service that has not been authorized by Molina, the Member will have to pay the cost of those services.

Utilization Review: Licensed Molina staff processes Prior Authorization requests and conducts concurrent review. Upon request, Providers and Members requesting authorization for Covered Services will be provided the criteria used for making coverage determinations. Molina provides assistance and informs Members of alternatives for care when a Member is not authorized for a service.

COORDINATION OF BENEFITS (COB)

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
For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Plan may release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision.

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. Molina 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 Molina should have paid under this COB provision, Molina may recover the excess from one or more of the persons Molina paid or for whom Molina 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 Molina has not paid a claim properly, you should first attempt to resolve the problem by contacting Molina. Follow the steps described in the "Appeals and Grievances" section. 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.dmhc.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.

COST SHARING

Molina requires Members to pay Cost Sharing for certain Covered Services under this Agreement. Members should review their Schedule of Benefits for all applicable Cost Sharing for Covered Services. For certain Covered Services, such as laboratory and X-rays that are provided on the same date of service and in the same location as an office visit to a PCP or a Specialist, Members will only be responsible for the applicable Cost Sharing amount for the office visit.

Members will be provided printed communication by default with their up-to-date accrual balance towards their annual Deductible and OOPM every month in which benefits are used until the accrual balance equals the full Deductible and/or OOPM amount. If Members do not wish to receive printed communication with this information, Members can opt out and access this information in real-time in the MyMolina Portal or by contacting Member Services. Members who opt out of receiving printed communications may opt back in at any time by contacting Member Services.

Members receiving covered inpatient hospital or skilled nursing facility services on the effective date of this Agreement pay the Cost Sharing in effect for this Agreement upon the effective date of coverage with Molina. For items ordered in advance, Members pay the Cost Sharing in effect for this Agreement upon the effective date, for Covered Services only. For outpatient prescription drugs, the order date is the date the Participating Provider pharmacy processes the order after receiving all the information they need to fill the prescription.

COVERED SERVICES

This section describes the Covered Services available with this Plan. Covered Services are available to current Members and may be subject to Cost Sharing, exclusions, limitations, authorization requirements, approvals and the terms and conditions of this Agreement. Molina will provide and pay for a Covered Service only if all of the following conditions are satisfied:

- The individual receiving Covered Services on the date the Covered Services are rendered is a Member;
- The Covered Services are Medically Necessary and/or approved by Molina;
- The services are identified as Covered Services in this Agreement;
- The Member receives Covered Services from a Participating Provider, except for Covered Services that are expressly covered when rendered by non-Participating Providers under the terms of this Agreement.

Members should read this Agreement completely and carefully in order to understand their coverage and to avoid being financially responsible for services that are not covered under this Agreement.

Essential Health Benefits: Covered Services for Members include Essential Health Benefits (EHB) as defined by the Affordable Care Act (ACA) and its corresponding federal regulations. Services that are not EHBs will be specifically described in this Agreement. EHB coverage includes at least the 10 categories of benefits identified in the ACA and its corresponding federal regulations. Members cannot be excluded from coverage in any of the 10 EHB categories. Please note, Members will not be eligible for EHB pediatric Covered Services under this Agreement as of 11:59 p.m. on the last day of the month that they turn age 19. This includes pediatric dental coverage and pediatric vision coverage.

Under the ACA and its corresponding federal regulations governing EHBs:

- Molina is not allowed to set lifetime limits or annual limits on the dollar value of EHBs provided under this Agreement.
- When EHB preventive services are provided by a Participating Provider, the

Member will not have to pay any Cost Sharing amounts.

- Molina must ensure that the Cost Sharing that Members pay for all EHBs does not exceed an annual limit that is determined under the ACA.

For the purposes of this EHB annual limit, Cost Sharing refers to any costs that a Member is required to pay for EHBs. Cost Sharing includes Deductibles, Coinsurance and Copayments, but excludes Premiums and Member spending on non-covered services.

Acupuncture Services: Molina covers 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.

Approved Clinical Trials: Molina covers routine patient care costs for qualifying Members participating in approved clinical trials for cancer and/or another life-threatening disease or condition. A Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Members will never be enrolled in a clinical trial without their consent.
To qualify for coverage, an enrolled Member must be diagnosed with cancer or other life-threatening disease or condition, be accepted into an Approved Clinical Trial (as defined below) and have received Prior Authorization or approval from Molina. An approved clinical trial means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and:

1. 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 a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants or
2. The study or investigation is conducted under an investigational new drug application reviewed by the FDA, or
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

All approvals and Prior 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. If a Member qualifies, Molina cannot deny their participation in an approved clinical trial. Molina cannot deny, limit, or place conditions on its coverage of Member’s routine patient costs associated with their participation in an approved clinical trial for which they qualify. Members will not be denied or excluded from any Covered Services under this Agreement based on their health condition or participation in a clinical trial. The cost of medications used in the direct clinical management of the Member will be covered unless the approved clinical trial is for the investigation of that drug or the medication is typically provided free of charge to Members in the clinical

trial. 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 the Member incurs these costs while in an approved clinical trial. Costs excluded from coverage under this Plan 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 inconsistent with the established standard of care for the patient's diagnosis. All approvals and Prior 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. For Covered Services related to an approved clinical trial, Cost Sharing will apply the same as if the service were not specifically related to an approved clinical trial. Members will pay the Cost Sharing they would pay if the services were not related to a clinical trial. Members should contact Member Services for further information.

Bariatric Surgery: Molina covers 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:

- Member must 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, the Member will pay the same Cost Sharing that would apply if the Covered Services were not related to a bariatric surgical procedure. For example, for hospital inpatient care, the Member would pay the Cost Sharing listed under "Inpatient Hospital Services" in the Schedule of Benefits.

Cancer Treatment: Molina provides the following coverages for cancer care and treatment, including, but not limited to:

- Preventive cancer screening and testing (please refer to the Preventive Services section of this Agreement for more information)
- Biomarker testing with no requirement for Prior Authorization for a Member with advanced or metastatic stage 3 or 4 cancer
- Diagnostic screening, laboratory, and procedures
- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare the Member's jaw for radiation therapy of cancer and other neoplastic diseases in the Member's head or neck
- Mastectomies (removal of breast) and lymph node dissections for the treatment of breast cancer
- Mastectomy-related services (please refer to the "Reconstructive Surgery" and "Prosthetic, Orthotic, Internal Implanted and External Devices" sections of this Agreement for more information)

- Routine patient care costs for Members who are participating in an Approved Clinical Trial for cancer (please refer to the “Approved Clinical Trials” section of this Agreement for more information)
- Prescription medications to treat cancer (please refer to the “Prescription Drug” section of this Agreement for more information)

Dental and Orthodontic Services: Molina has partnered with California Dental Network, Inc. to administer pediatric dental benefits for Members up to age 19. Pediatric dental benefits include preventive, diagnostic, routine, major and orthodontia services as outlined in the Pediatric Dental Services addendum attached to this Agreement.

Otherwise, dental and orthodontic services provided under this agreement for adults and children must be Prior Authorized and are limited to the following:

- Dental services for radiation treatment
- Dental anesthesia when Medically Necessary
- Dental and Orthodontic services for cleft palate
- Services to treat Temporomandibular Joint Syndrome (TMJ) (Please refer to the Temporomandibular Joint Syndrome section of this Agreement)
- Dental services needed due to accidental injury

Diabetes Services: Molina covers the following diabetes-related services:

- Diabetes self-management training and education when provided by a Participating Provider
- Diabetic eye examinations (dilated retinal examinations)
- Easy to read diabetic health education materials
- Medical nutrition therapy in an outpatient, inpatient or home health setting
- Outpatient self-management training
- Routine foot care (including for care of corns, bunions, calluses, or debridement of nails).
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider who is a podiatrist
- Preventive Services including:
    - Diabetes education and self-management
    - Diabetes (Type 2) screening
    - Screening for gestational diabetes
- Dietician services
- Nutritional counseling

For information regarding diabetes supplies, please refer to the “Prescription Drugs” section.

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

- The services are provided inside the Service Area.
- The Member satisfies all medical criteria developed by Molina
- A Participating Provider physician provides a written referral for care at the facility

After a Member receives appropriate training at a Molina approved and designated dialysis facility, Molina also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside the Service Area. Coverage is limited

to the standard item of equipment or supplies that adequately meets the Member’s medical needs. Molina decides whether to rent or purchase the equipment and supplies, and Molina selects the vendor. The Member must return the equipment and any unused supplies or pay the fair market price of the equipment and any unused supply when they are no longer covered.

Durable Medical Equipment (DME): Molina covers rental or purchase of certain DME. Molina also covers reasonable repairs, maintenance, delivery, and related supplies for DME. The DME must be provided through a vendor that is contracted with Molina. Prior Authorization is required.

Emergency Services

Emergency Services are available 24 hours a day, 7 days a week for Members. Members who think they are having an Emergency should call **911** right away and go to the closest Emergency facility. When receiving Emergency Services, Members should bring their Member ID card. Members who do not believe they need Emergency Services but who need medical help should call the 24-Hour Nurse Advice Line toll-free or contact their PCP. Members should not go to an Emergency room if the condition is not an Emergency.

Emergency Services When Out of Service Area: Members should go to the nearest Emergency room for care when outside the Molina Service Area when they think they are having an Emergency. Please contact Member Services within 24 hours or as soon as possible.

Emergency Services by a Non-Participating Provider: Emergency Services for treatment of an Emergency Medical Condition are subject to Cost Sharing. This is true whether Emergency Services are provided by Participating Providers or Non-Participating Providers. Members should refer to the Cost Sharing for Emergency Services in the Schedule of Benefits.

Important: Except as otherwise required by State Law, when Emergency Services are received from Non-Participating Providers for the treatment of an Emergency Medical Condition, claims for Emergency Services will be paid at Molina’s Allowed Amount. A Non-Participating Provider in California may not Balance Bill a Member for the difference between Molina’s Allowed Amount and the rate the Provider charges for Emergency Services.

Mandatory Transfer to a Participating Provider Hospital: Prior Authorization is required to get Hospital services, except in the case of Emergency Services. For Members who are admitted to a Non-Participating Provider facility for Emergency Services, Molina reserves the right to require a transfer to a Participating Provider facility once the Member has stabilized sufficiently. If Molina requires a transfer, Molina will work with the Member and their Provider to provide transportation to a Participating Provider facility. If the Member’s coverage terminates during a Hospital stay, the services received after the termination date are not Covered Services. If the Member’s Provider determines they are stable for transfer and Molina arranges for transfer to a Participating Provider facility, and the Member refuses the transfer, additional services provided in the Non-Participating Provider facility are not Covered Services, the Member will be 100% responsible for payments, and the payments will not apply to the Deductible or OOPM.

Emergency Services Outside the United States: Covered Services include Emergency Services while traveling outside of the Service Area. This includes travel outside of the United States. For Emergency Services while traveling outside the United States, Members should use that country's or territory's emergency telephone number or go to the nearest emergency room.

Members who receive Emergency Services while traveling outside the United States will be required to pay the Non-Participating Provider's charges at the time they obtain those services. Members may submit a claim for reimbursement to Molina for charges that they paid for Covered Services received from the Non-Participating Provider.

Members are responsible for ensuring that claims and/or records of such services are appropriately translated. They are also responsible for ensuring that the monetary exchange rate is clearly identified when submitting claims for Emergency Services received outside the United States. Medical records of treatment and service may also be required for proper reimbursement from Molina. Claims for reimbursement for Covered Services should be submitted to the mailing address on the first page of this Agreement.

Claims for reimbursement of Covered Services for Members traveling outside the United States must be verified by Molina before payment can be made. Molina will calculate the Allowed Amount that will be covered for Emergency Services while traveling outside of the Service Area, in accordance with applicable state and federal laws.

Because these services are performed by a Non-Participating Provider, Members will only be reimbursed for the Allowed Amount. The Allowed Amount may be less than the amount the Member was charged by the Non-Participating Provider. Members will not be entitled to reimbursement for charges for health care services or treatment that are not covered under this Agreement.

Emergency Medical Transportation: Emergency medical transportation (ground and air ambulance), or ambulance transport services provided through the 911 emergency response system are covered when Medically Necessary or when a Member reasonably believes there is an Emergency. Balance Billing is prohibited in California.

Family Planning: Molina covers family planning services, including:

- Diagnosis and treatment of sexually transmitted diseases (STDs) if medically indicated, including home test kits and the laboratory processing for those kits when ordered by a Participating Provider
- Prescription birth control, including emergency birth control when filled by a Participating Provider pharmacist, or by a Non-Participating Provider in the event of an Emergency.
- Over-the-counter birth control products listed on the Formulary, with prescription at network pharmacies
- Over-the-counter emergency contraception ("morning after pills") without prescription at network pharmacies
- The plan covers one version of every available contraceptive drug. When a generic is available, the generic is covered. When a generic is not available, the brand is covered.
- Follow-up care for any problems Members may have using birth control methods issued by the family planning providers

- Laboratory tests if medically indicated as part of deciding what birth control methods a Member might want to use
- Pregnancy testing and counseling
- Screening, testing and counseling of at-risk individuals for HIV and referral for treatment
- Voluntary sterilization services, including tubal ligation (for females) and vasectomies (for males)
- Any other outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain or remove a contraceptive.

Habilitation Services: Molina covers healthcare services and authorized devices that help a person with disabilities or chronic conditions to keep, learn, or improve skills and functioning for daily living. These include physical, speech and occupational therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Healthcare: Molina covers home healthcare services on a part-time, intermittent basis to a Member confined to his or her home due to physical illness – when Prior Authorized and provided by a contracted home healthcare agency. Molina covers the following home healthcare services:

- In-home medical care services
- Home health aide services
- Medical social services
- Medical supplies other than drugs and biologicals
- Necessary medical appliances, provided for under an approved treatment plan
- Part-time skilled nursing services by licensed nursing personnel
- Physical, occupational, speech or respiratory therapy

The following home healthcare services are covered under this plan:

- Up to 2 hours per visit by a nurse, medical social worker, physical, occupational, or speech therapist and up to 4 hours per visit by a home health aide
- Up to 100 visits per calendar year (counting all home health visits)

Hospice Services: Molina covers hospice services for Members who are terminally ill (a life expectancy of 12 months or less). Members can choose hospice care instead of the traditional services covered by this Plan. Molina covers home hospice services and a semi-private room in a hospice facility. Molina also covers respite care for up to 7 days per occurrence.

Inpatient Hospital Services: Members must have a Prior Authorization to receive covered hospital services, except in the case of an Emergency or out-of-area Urgent Care Services. Services received in a Non-Participating Provider hospital after admission to the hospital for Emergency Services or out-of-area Urgent Care Services will be covered until the Member has stabilized sufficiently to be transferred to a Participating Provider facility, provided the Member's coverage with Molina has not terminated. Molina will work with the Member and their Provider to provide medically appropriate transportation to a Participating Provider facility. If coverage with Molina terminates during a hospital stay, the services received after the Member's termination date are not Covered Services. After stabilization and after provision of transportation to a Participating Provider facility, services or admission provided in a Non-Participating Provider hospital are not Covered Services, the Member will be 100% responsible for payments to any Non-Participating Providers, and the Member's payments will not apply to the Deductible or OOPM.

Medically Necessary inpatient services are generally and customarily provided by acute care general hospitals inside the Service Area. Non-covered services include, but are not limited to, private duty nursing, guest trays and patient convenience items

Laboratory Tests, Radiology (X-Rays), and Specialized Scanning Services: Molina covers laboratory, radiology (including X-ray) and scanning services at a Participating Provider. Covered scanning services can include CT Scans, PET Scans and MRI with Prior Authorization. Molina can assist Members to select an appropriate facility for these services. Separate Cost Sharing may apply for professional services and facility services. The Member must receive these services from Participating Providers; otherwise, the services are not covered, the Member will be 100% responsible for payment to Non-Participating Providers, and the payments will not apply to the Deductible or OOPM

Mental Health Services: Molina covers medically necessary treatment of a mental health or substance use disorder, including services for the treatment of gender dysphoria, only when that disorder is listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

"Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the state-required non-profit professional association standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Outpatient care for treatment of mental health disorder does not include therapy or counseling for primary diagnosis of any of the following: career, marriage, divorce, parental, or job counseling or therapy.

Molina generally covers the following Medically Necessary Mental Health Services:

- Inpatient care
- Crisis stabilization
- Short-term residential treatment services
- Partial hospitalization programs for mental health
- Intensive outpatient programs for adults and day treatment for children
- Psychological and neuropsychological testing
- Behavioral health procedures

Autism Spectrum Disorder: Molina covers the diagnosis and treatment of autism spectrum disorders including autistic disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified, as defined by the most recent version of the DSM.

Mental Health Parity and Addiction Equity Act: Molina complies with the federal Mental Health Parity and Addiction Equity Act. Molina ensures that the financial requirements and treatment limitations on Mental Health Services or Substance Use Disorder benefits provided are no more restrictive than those on medical or surgical benefits.

Non-Emergency Medical Transportation: Non-Emergency ambulance and psychiatric transport van services are covered if a Participating Provider determines that a Member's 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 the Member's health. These services are covered only when the vehicle transports the Member to or from Covered Services. The Member must have Prior Authorization from Molina 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.

Phenylketonuria (PKU) and Other Inborn Errors of Metabolism: Molina covers testing and treatment of phenylketonuria (PKU). Molina also covers 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. Other specialized formulas and nutritional supplements are not covered. Prescription Drug Cost Sharing will apply.

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

Physician Services: Molina covers the following outpatient physician services including, but not limited to:

- Office visits, including:
  - Associated medical supplies
  - Pre-natal and post-natal visits
- Chemotherapy and other Provider-administered drugs whether administered in a physician’s office, an outpatient or an inpatient setting.
- Diagnostic procedures, including colonoscopies; cardiovascular testing, including pulmonary function studies; and neurology/neuromuscular procedures
- Radiation therapy
- Routine pediatric and adult health exams
- Injections, allergy tests and treatment
- Routine examinations and prenatal care provided by an OB/GYN. Members may select an OB/GYN as their PCP. Dependents have direct access to obstetrical and gynecological care.
- Sleep studies (Separate facility Cost Sharing may apply.)
- Adverse childhood experiences (ACEs) screenings

Pregnancy and Maternity: For prenatal care, Members may choose any Molina Participating Provider who is either an obstetrician/gynecologist (OB/GYN), certified nurse midwife, or nurse practitioner who is trained in women’s health. Molina covers the following maternity care services:

- Outpatient maternity care including Medically Necessary supplies for a home birth
- Services for complications of pregnancy, including fetal distress, gestational diabetes and toxemia. “Complications of pregnancy” means a condition due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section are not complications of pregnancy.
- Screening for maternal mental health conditions
- Laboratory services
- Inpatient hospital care and birthing center care for 48 hours after a normal vaginal delivery or 96 hours following a delivery by Cesarean section (C-section). Longer stays require that Members or Member’s provider notifies Molina.

After talking with a Member, if the Member’s Provider decides to discharge the Member and their newborn before the 48- or 96-hour period, Molina will cover post-discharge services and laboratory services. Preventive, primary care, and laboratory services Cost Sharing will apply to post-discharge services, as applicable.

Pregnancy Termination: Molina covers pregnancy termination services subject to certain coverage restrictions required by the Affordable Care Act and by any applicable California laws without Cost Sharing. Outpatient procedures do not require Prior Authorization. If the pregnancy termination service will be provided in an inpatient setting, Prior Authorization is required.

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

Preventive Services: In accordance with the Affordable Care Act and as part of Member's Essential Health Benefits, Molina covers preventive services at no Cost Sharing for Members. Preventive services include:

- 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). Please visit the USPSTF website for preventive services recommendations at: https://www.uspreventiveservicestaskforce.org
- Immunizations for routine use in children, adolescents, and adults as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC).
- 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).
- Preventive services and screenings provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

All preventive services must be furnished by a Participating Provider to be covered under this Agreement. As new recommendations and guidelines for preventive services are published and recommended by the government agencies identified above, they will become covered under this Agreement. Coverage will start for product years that begin one year after the date the recommendation or guideline is issued or on such other date as required by the ACA and its implementing regulations. The Plan 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 ACA, its corresponding federal regulations and applicable State Law.

Prosthetic, Orthotic, Internal Implanted and External Devices: Molina covers the prosthetic and orthotic devices described in this 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 the Member's medical needs.
- The Member receives the device from the provider or vendor that Molina selects.

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 the Member needs a prosthetic or orthotic device. If Molina covers a replacement device, then the Member pays the Cost Sharing that would apply for obtaining that device, as specified below.

Internally implanted devices: Molina covers internally implanted devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints if these devices are implanted during a surgery that is otherwise covered by Molina. 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 internally implanted devices.

External devices: Durable Medical Equipment Cost Sharing applies for the following external prosthetic and orthotic devices.

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

Reconstructive Surgery: Molina covers the following reconstructive surgery services when Prior Authorized:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease such that surgery is necessary to improve function or create a normal appearance, to the extent possible.
- Removal of all or part of a breast (mastectomy), reconstruction of the breast following a Medically Necessary mastectomy, surgery and reconstruction of the other breast to produce a symmetrical appearance following reconstruction of one breast, and treatment of physical complications, including lymphedemas.

The following reconstructive surgery services are not covered:

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

Rehabilitation Services: Molina covers 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.

Routine Foot Care: Molina covers Medically Necessary routine foot care including for care of corns, bunions, calluses, or debridement of nails.

Skilled Nursing Facility: Molina covers 100 days per benefit period at a Skilled Nursing Facility (SNF) for a Member when the SNF is a Participating Provider and the services are Prior Authorized before they begin. Covered SNF services include:

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

A benefit period begins on the date the Member is admitted to a hospital or SNF at a skilled level of care and ends on the date the Member has not been an inpatient in a hospital or SNF, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior 3-day stay in an acute care hospital is not required to commence a benefit period.

Substance Use Disorder (Inpatient and Outpatient): Molina covers Medically Necessary inpatient and outpatient treatment for substance use disorder based upon non-profit professional association criteria. Inpatient coverage, in a Participating Provider hospital, is covered for medical management of withdrawal symptoms. Molina also provides coverage for substance use disorder treatment in a nonmedical transitional residential recovery setting when Prior Authorized. Molina covers the following outpatient care for treatment of substance use disorder:

- Short-term residential programs
- Day-treatment/partial programs
- Individual and group substance use disorder counseling
- Individual substance use disorder evaluation and treatment
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Medication-Assisted Treatment (MAT)
- Opioid Treatment Programs (OTPs)

Outpatient care for treatment of substance use disorder does not include therapy or counseling for primary diagnosis of any of the following: career, marriage, divorce, parental, job, learning disabilities, and intellectual disability.

Surgery (Inpatient and Outpatient): Molina covers the inpatient and outpatient surgical services listed below when provided at a Participating Provider facility. Prior Authorization is required.
Inpatient surgical services include:

- Anesthesia
- Antineoplastic surgical drugs
- Discharge planning
- Operating and recovery rooms

Outpatient surgery services provided in any of the following locations:

- Outpatient or ambulatory surgery center
- Hospital operating room
- Clinic
- Physician’s office.

Separate Cost Sharing may apply for professional services and facility services. Please consult the Schedule of Benefits for Outpatient Hospital/Facility Services or Inpatient Hospital Services to determine applicable Member Cost-Sharing.

Temporomandibular Joint Syndrome ("TMJ") Services: Molina covers services to treat temporomandibular joint syndrome if all the following conditions apply:

- The condition is caused by a congenital, developmental or acquired deformity, disease or injury.
- Under the accepted standards of the profession of the health care provider rendering the service, the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition.
- The purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction.

Transplant Services: Molina covers transplants of organs, tissue, or bone marrow at Participating Provider facilities when Prior Authorized. If a Participating Provider determines that a Member does not satisfy its respective criteria for a transplant, Molina will only cover services the Member received before that determination is made. Molina is not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor. In accordance with Molina guidelines for services for living transplant donors, Molina provides certain donation-related services for a donor, or an individual identified as a potential donor, regardless of whether the donor is a Member. These services must be directly related to a covered transplant for the Member. Covered Services may include certain services for evaluation, organ removal, direct follow-up care, harvesting the organ, tissue, or bone marrow and for treatment of complications. Molina guidelines for donor services are available by calling Member Services.

Urgent Care Services: Urgent Care Services are subject to the Cost Sharing in the Schedule of Benefits. Urgent Care Services are those services needed to prevent the serious deterioration of one's health from an unforeseen medical condition or injury. For after-hours or Urgent Care Services, Members should call their PCP or the Nurse Advice Line. Members who are within the Service Area can ask their PCP what Participating Provider urgent care center to use. It is best to find out the name of a Participating Provider urgent care center ahead of time. Members must get Urgent Care Services from a Participating Provider, except that Members who are outside of the Service Area may go to the nearest emergency room for Urgent Care Services.

Vision Services (Adult and Pediatric): All Members are covered for diabetic eye examinations (dilated retinal examinations), as well as 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, to correction of refractive defects of the eye (such as myopia, hyperopia, or astigmatism), or to the purchase or fitting of eyeglasses or contact lenses, except as described in this "Vision Services" section. Laser corrective surgery is not covered.

Specialty Vision Services: Molina covers the following special contact lenses when prescribed by a Participating Provider, subject to Specialist office visit Cost Sharing:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris), whether provided by the plan during the current or a previous 12-month contract period.
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye), whether provided by the plan under the current or a previous contract in the same calendar year.

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

- Routine vision screening and eye exam every calendar year, including refraction, and including dilation when professionally indicated.
- One pair of prescription glasses (frames and lenses) every calendar year with glass, plastic, or polycarbonate lenses; available in single vision, conventional bifocal, conventional trifocal, and lenticular lenses in all lens powers.
- Contact lens exam (fitting and evaluation), including standard and premium fits covered in full.
- Prescription contact lenses are available instead of glasses. Members can choose from any available prescription contact lens material, including a minimum 3-month supply for any of the following modalities: standard (1 pair annually), monthly (6-month supply), bi-weekly (3-month supply), dailies (3-month supply).
- Necessary contact lenses are 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. Refer to “Specialty Vision Services” above 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 comprehensive low-vision evaluation every 5 years.
  - High-powered spectacles, magnifiers and telescopes as Medically Necessary.
  - Follow-up care, including 4 visits in any 5-year period.

PRESCRIPTION DRUGS

Drugs, Medications and Durable Medical Equipment: Molina covers drugs ordered by Providers, approved by Molina, and filled through a pharmacy that is a Molina contracted pharmacy. Covered drugs include over-the-counter (OTC) and prescription drugs on the Formulary. Molina also covers medical drugs ordered or given in a participating facility when provided in connection with a Covered Service. Prior Authorization may be required to have certain drugs covered. A Provider who is lawfully permitted to write prescriptions, also known as a Prescriber, may request Prior Authorization on behalf of a Member, and Molina will notify the Provider if the request is either approved or denied based upon Medical Necessity review.

Pharmacies: Molina covers drugs at retail pharmacies, specialty pharmacies, and mail order pharmacies within our Service Area. Members may be required to fill a drug with a contracted specialty pharmacy if the drug is subject to Food and Drug Administration (FDA) restrictions on distribution, requires special handling or Provider coordination, or if specialized patient education is required to ensure safe and effective use. Drugs may be covered outside the Service Area for Emergency Services only, upon request. For a list of contracted pharmacies, please visit www.MolinaMarketplace.com. A hardcopy is also available upon request made to Member Services.

Molina Formulary: Molina establishes a list of drugs, devices, and supplies that are covered under the Plan's pharmacy benefit. The list of covered products is referred to as the "Formulary". The list shows all the prescription and over-the-counter products Plan Members can get from a pharmacy, along with any coverage requirements, limitations, or restrictions on the listed products. The Formulary is available to Members on MolinaMarketplace.com. A hardcopy is also available upon request. The list of products on the Formulary are chosen by a group of medical professionals from inside and outside of Molina. This group reviews the Formulary regularly and makes changes every three months based on updates in evidence-based medical practice, medical technology, and new-to-market branded and generic drugs.

Formulary Exception Requests

Access to Nonformulary Drugs: Molina members can request coverage of clinically appropriate drugs that are not on the formulary, or have "step therapy" or other requirements that have not been met. Drugs that are not on the formulary may not be covered by the plan. These drugs may cost members more than similar drugs that are on the formulary if covered on "exception," as described in the next sections. To ask for nonformulary drugs to be covered, a provider can submit a formulary exception request on a member's behalf. These requests will be considered for a medically accepted use when formulary options cannot be used, and other coverage requirements are met. A member's response to drug samples from a provider or a drug maker is not a reason to bypass standard rules for plan drug coverage.

Formulary drugs are typically prescribed by providers for members to get from a pharmacy and give themselves. Most injectable drugs that require a provider's help are covered under the medical benefit instead of the pharmacy benefit. Providers have instructions from Molina on how to get advanced approval for members' drugs. Some injectable drugs can be approved through the exceptions process to get from a pharmacy using the plan pharmacy benefit.

Non-Covered Drugs: Non-covered drugs such as benefit exclusions are not covered at all. They cannot be approved for coverage by formulary exception. Molina does not cover certain types of drugs that are listed as benefit exclusions in the plan policy, including:

- Cosmetic drugs
- Drugs not FDA-approved or licensed for use in the United States
- Drugs to treat erectile dysfunction or other types of sexual dysfunction
- Experimental and Investigational drugs or uses of drugs
- Gene therapy
- Hair loss or growth treatments

- Homeopathic treatments and nutritional supplements
- Infertility drugs (other than treating and underlying infertility cause itself)
- Over-the-counter drugs not listed on the formulary
- Proposed less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Weight loss drugs

Requesting a Formulary Exception: The process for requesting a formulary exception is the same for requesting prior authorization on formulary drugs that require advanced approval for coverage. Requests are reviewed against standard rules to determine medical necessity.

A provider may fax a completed Prior Authorization/Medication Exception Request form to Molina at 1 (866) 508-6445. The form may be obtained on MolinaMarketplace.com at the provider forms and documents page. The form must be completed and include all medical information. Otherwise, it will not be accepted.

Molina will grant an exception for a nonformulary drug or step therapy requirement if its reviewers determine the supporting information shows any of the following:

- The member has a medical contraindication to formulary or required drug(s)
- The required drug(s) will likely cause a clinically predictable adverse reaction if taken by the member
- The required drug is expected to be ineffective based on the member's documented clinical characteristics
- The member has tried the required drug, a related drug, or a drug that works in a similar way, and discontinued it due to lack of effectiveness, loss of effect, or adverse event
- The member is established on the drug as a current treatment from previous insurance coverage. If the established drug is a brand drug and we cover the generic or interchangeable biological product, an exception may be given if switching to the required drug will likely cause clinically predictable adverse reactions or harm
- The supporting medical information clearly shows formulary or required drugs are not in the member's best interest, because they are likely to:
  - Present a barrier to treatment plan adherence, or
  - Negatively impact a member's comorbid condition, or
  - Cause a clinically predictable negative drug interaction, or
  - Decrease the member's ability to achieve or maintain reasonable functional ability in performing daily activities

After receiving all the needed information from the member's provider, Molina will notify the member's treating provider of approval or denial of the request:

- Within 72 hours for standard requests, and
- Within 24 hours for urgent requests

Urgent exception requests apply when a member is experiencing a health situation that may seriously jeopardize their life, health, or ability to regain maximum function, or when a member is undergoing a current course of treatment using a nonformulary drug.

If the request is denied, Molina Healthcare will send a letter to the member and their prescriber. The letter will explain why the drug or product was denied. The prescriber may request to discuss the denial with Molina. If the member disagrees with the denial of the request, the member can appeal Molina's coverage decision. The prescriber may also request that an Independent Review Organization (IRO) review Molina's coverage decision during an appeal. The IRO will notify the requestor of the IRO decision no later than:

- 72 hours following receipt of an appeal of a denied standard exception request
- 24 hours following receipt of an appeal on a denied urgent exception request

Cost Sharing: Molina puts drugs on different levels called tiers based on how well they improve health and their value compared to similar treatments. The Schedule of Benefits shows Member Cost Share for a one-month supply based on these tiers.

Here are some details about which drugs are on which tiers.

Drug Tier	Description
Tier 1	1) Most generic drugs and low-cost preferred brands.
Tier 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.
Tier 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.
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 5	Nationally recognized preventative service drugs and dosage forms, and family planning drugs and devices (i.e., contraception) with $0 cost sharing.
DME	Durable Medical Equipment ("DME") - cost sharing applies; some non-drug products on the Formulary have cost sharing determined by the DME coinsurance.

Members 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 the Member pays for a covered drug will constitute the applicable Cost Sharing. The retail-price payment will apply to both the Deductible, if any, and the OOPM.

Cost Sharing on Formulary Exceptions: For drugs or other products that are approved on Formulary exception, the Member will have Tier 3 cost share for non-

specialty products or a Tier 4 cost share for Specialty products. Please note, for nonformulary brand-name products that have a generic product listed on the Formulary, if coverage is approved on exception, a Member's share of the cost will also include the difference in cost between the Formulary generic drug and the brand-name drug.

Drug Cost Sharing Assistance and Out-of-Pocket Costs: Cost Sharing reduction for any prescription drugs obtained by Members through the use of a discount card, a coupon provided by a prescription drug manufacturer, or any form of prescription drug third party Cost Sharing assistance will not apply toward any Deductible, or the OOPM under the Plan.

Over-the-Counter Drugs, Products and Supplements: Molina covers over-the-counter drugs, products and supplements in accordance with State Law and federal laws. Only over-the-counter drugs, supplies, and supplements that appear on the Formulary may be covered.

Durable Medical Equipment (DME): Molina will cover DME rental or purchase costs for use with certain drugs when obtained through a contracted vendor. Molina will also cover reasonable repairs, maintenance, delivery, and related supplies for DME. Members may be responsible for necessary DME repair or replacement costs if needed due to misuse or loss of the DME. Prior Authorization may be required for DME to be covered. Coverage may be under the medical benefit or the pharmacy benefit, depending on the type of DME. Please refer to the Formulary for DME and other non-drug products covered under the pharmacy benefit. Please refer to MolinaMarketplace.com or contact Member Services for more coverage information.

Diabetic Supplies: Molina covers diabetic supplies on the Formulary such as insulin syringes, lancets and lancet puncture devices, blood glucose monitors, continuous glucose monitoring DME, blood glucose test strips, urine test strips, and select pen delivery systems for the administration of insulin.

Prescription Drugs to Stop Smoking: Molina covers drugs to help Members stop smoking, with no Cost Share. Members should consult their Provider to determine which drug is right for them. Covered drugs are listed on the Formulary.

Day Supply Limit: While Providers determine how much drug, product supply, or supplement to prescribe, Molina may only cover one month of supply at a time for certain products. The Formulary indicates "MAIL" for items that may be covered with a 3-month supply through a contracted mail order pharmacy or other Plan programs. Quantities that exceed the day supply limits on the Formulary are not covered, with few exceptions.

Up to a 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 30-day supply limit and 90-day mail order supply limit do not necessarily apply for the up-to-12-month supply for FDA-approved, self-administered hormonal contraceptives. Otherwise, quantities that exceed the day supply limit are not covered unless Prior Authorized.

Proration and Synchronization: Molina provides medication proration for a partial supply of a prescription drug if the Member's pharmacy notifies Molina that the quantity dispensed is to synchronize the dates that the pharmacy dispenses the prescription drugs, synchronization is in the best interest of the Member, and Member agrees to the synchronization. The proration described will be based on the number of days' supply of the drug dispensed.

Opioid Analgesics for Chronic Pain: Prior Authorization may be required for pharmacy coverage of opioid pain medications to treat chronic pain. Without a Prior Authorization, opioid claims have safety limits, including a shorter supply per fill and restrictions on long-acting opioid drugs and combined total daily doses. These requirements do not apply to Members in the following circumstances: Opioid analgesics are prescribed to a Member who is a hospice patient, the Member was diagnosed with a terminal condition, or the Member is actively being treated for cancer. Molina will conduct a utilization review for all opioid Prior Authorization requests.

Drugs to Treat Cancer: Molina covers reasonable costs for anti-cancer drugs and their administration. Prior Authorization requests for drugs to be used outside the FDA labeling (i.e., off-label uses) are reviewed for Medical Necessity. These requests are reviewed against standard recommendations for the use of the drug and for the type of cancer being treated. No request is denied solely based on non-FDA label use. Drugs that Providers treat Members with will be subject to Cost Sharing specified for chemotherapy under the medical benefit for the site where treatment is given. Drugs that Members get from pharmacies will be subject to Cost Sharing specified for the pharmacy benefit. Please refer to the Schedule of Benefits for applicable Cost Sharing. Most new anti-cancer drugs require special handling and education and are considered Tier 4 specialty drugs under the pharmacy benefit. All anti-cancer drugs taken by mouth and paid for under the pharmacy benefit will be covered on the same basis and at no greater Cost Sharing than imposed under the medical benefit for anti-cancer drugs given by other bodily routes by a Provider. The maximum Cost Sharing for an orally administered anti-cancer medication is $250 for up to a 30-day supply and is not subject to a deductible.

Treatment of Human Immunodeficiency Virus (HIV): Molina covers prescription drugs for the treatment of HIV infection, or an illness or medical condition arising from or related to HIV. Drugs must be prescribed within the Provider's scope of practice and approved by the United States Food and Drug Administration (FDA), including Phase III experimental or investigational drugs that are FDA approved and are administered according to protocol.

Mail Order Availability of Formulary Drugs: Molina offers Members a mail order option for certain drugs in tiers 1, 2, 3 and 5. Eligible drugs are marked "MAIL" on the Formulary. Formulary drugs will be mailed to a Member within 10 days from order request and approval. Through this option, Members can get a 3-month supply of eligible drugs at reduced Cost Sharing. Cost Sharing for a 3-month supply through mail order is applied at a rate of two and a half times the 1-month supply Cost Sharing at the drug's Formulary tier. Tier 4 Specialty drugs are not eligible for mail order programs, though most Specialty medications will be shipped to the Member directly. Refer to MolinaMarketplace.com or contact Member Services for more information.

Off-Label Drugs: Molina will not deny coverage of off-label drug use solely on the basis that the drug will be used outside of the FDA-approved labeling. Molina does cover off-label drug use to treat a covered, chronic, disabling, or life-threatening illness. The drug must be approved by the FDA for at least one indication. The use must be recognized as standard and effective for treatment of the indication in any of the standard drug reference compendia or substantially accepted peer-reviewed medical literature. Molina may require that other treatments that are also standard have been tried or are not clinically appropriate if permitted under state law. The off-label drug use request must demonstrate Medical Necessity to treat a covered condition when Prior Authorization is required.

Non-Covered Drugs: Molina does not cover certain drugs, including but not limited to:

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

Molina does not cover drugs to treat conditions that are benefit exclusions, including but not limited to:

- Cosmetic services
- Hair loss or growth treatment
- Erectile dysfunction
- Sexual dysfunction

Information on Prescription Drug Coverage: In addition to the information provided in this Agreement, Molina provides telephonic and online resources for Members and Providers to get specific coverage and Cost Sharing information. Members can call Member Services for this information. Providers can call pharmacy provider services for this information. Members and Providers can look up information online using the posted Formulary or the “Search Drugs” tool at MolinaMarketplace.com. Formulary information is also available to the prescriber within electronic prescribing software if using a compatible electronic health record. Molina’s Pharmacy Benefit Manager, Caremark®, uses Surescripts® Real-Time Prescription Benefit interoperability to give prescribers visibility to Formulary information at the point-of-prescribing. Through these available resources Members and Providers can get information on all of the following details of prescription drug coverage (not all of these may be available in a single resource):

- Whether the drug is covered for the Member
- The most current covered drug list
- Cost Sharing information for the prescription drug and alternatives on the Formulary (For self-service Cost Sharing details, use the Search Drug tool online)
- Whether the drug is eligible for mail order or other 90-day programs, and the applicable Cost Sharing information (For self-service details, see the Formulary or the Search Drug tool online)
- Coverage requirement details like Prior Authorization, step therapy, age limits, and so on (For self-service details, see the Formulary online)

EXCLUSIONS

Certain equipment and services are 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, except where expressly stated otherwise in this Section, or where otherwise required by State Law. This is not an exhaustive list of services that are excluded from coverage under this Plan. Please contact Molina Member Services for questions regarding exclusions.

Aquatic Therapy: Aquatic therapy and other water therapy are not covered, unless Medically Necessary as part of a physical therapy treatment plan covered under the "Covered Services" section of this Agreement. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Artificial Insemination and Conception by Artificial Means: All services related to artificial insemination and conception by artificial means are not covered.

Certain Exams and Services: The following are not covered unless a Participating Provider determines that the services are Medically Necessary.

- Physical exams and other services that are:
    - Required for obtaining or maintaining employment or participation in employee programs
    - Required for medical coverage, life insurance coverage or licensing, or
    - On court order or required for parole or probation.

Chiropractic Services: Chiropractic services are not covered. This exclusion does not apply to any services specifically covered in any section of this Agreement, including the Habilitation and Rehabilitation Services sections.

Cosmetic Services: Services that are intended primarily to change or maintain a Member's physical appearance are not covered. This exclusion does not apply to any services specifically covered under the "Covered Services" section of this Agreement. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Custodial Care: Assistance with activities of daily living are not covered. This exclusion does not apply to assistance with activities of daily living provided as part of covered hospice, skilled nursing facility, or inpatient hospital care. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Dietitian: A service of a dietician is not a Covered Service except for hospice benefits or as described in the section titled, "Phenylketonuria (PKU) and Other Inborn Errors of Metabolism." This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Disposable Supplies: Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, underpads, and other incontinence supplies are not covered.

Erectile Dysfunction: Molina does not cover drugs or treatment for erectile dysfunction. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Experimental or Investigational Services: Molina does not cover Experimental or Investigational services; however, this exclusion does not apply to Services covered under Approved Clinical Trials section.

Hair Loss or Growth Treatment: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth are not covered. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

Infertility Services All infertility services and supplies are not covered, other than Medically Necessary iatrogenic fertility preservation services.

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to services covered under the "Covered Services" section of this Agreement.

Non-Healthcare Items and Services: Molina does not cover services that are not healthcare services, for example:

- 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 Members how to read, if they have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming, unless medically necessary for treatment of a mental health or substance use disorder.
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional-growth courses
- Training for a specific job or employment counseling
- Examinations related to job, athletic (sports physicals), or recreational performance

Massage Therapy: Massage therapy is not covered, unless Medically Necessary as part of a physical therapy treatment plan covered under the "Covered Services" section of this Agreement.

Oral Nutrition: Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, supplements, herbal supplements, weight loss aids, and food. This exclusion does not apply to services covered under the "Phenylketonuria (PKU) and Other Inborn Errors of Metabolism" section of this Agreement.

Private Duty Nursing: Nursing services provided in a facility or private home, usually to one patient, are not covered. Private duty nursing services are generally provided by independently contracted nurses, rather than through an agency, such as a home healthcare agency.

Residential Care: Care in a facility where a Member's stay overnight is not covered; however, this exclusion does not apply when the overnight stay is part of covered care in any of the following:

- A Hospital,
- A skilled nursing facility,
- Inpatient respite care covered in the "Hospice Services" section,
- A licensed facility providing crisis residential services covered under Mental Health Services (inpatient and Outpatient) section, or
- A licensed facility providing transitional residential recovery services covered under the Substance Use Disorder (Inpatient and Outpatient) section.

Services Not Approved by the FDA: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA are not covered. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to services covered under Approved Clinical Trials section of this Agreement. Please refer to the Appeals and Grievances section of this Agreement for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Any services and supplies provided to a Member outside the Service Area where the Member traveled to the location for the purposes of receiving medical services, supplies, or drugs are not covered. Also, routine care, preventive care, primary care, specialty care, and inpatient services are not covered when furnished outside the Service Area, except for Emergency Services and Urgent Care Services covered under the Covered Services section of this Agreement. . When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Member Services for more information.

Services Performed by Unlicensed People: Services performed by people who are not required by State Law to possess valid licenses or certificates to provide healthcare services are not covered, except otherwise covered by this Agreement. This exclusion does not apply to services deemed medically necessary treatment of a mental health or substance use disorder.

Services Related to a Non-Covered Service When a service is not covered, all services related to the non-covered service are not covered. This exclusion does not apply to services Molina 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.

Sexual Dysfunction: Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications. This exclusion does not apply to medically necessary treatment of a mental health or substance use disorder.

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 "Legal Notices" section of this Agreement for information about Member obligations to Molina in connection with a Surrogacy Arrangement, including Member obligations to reimburse Molina for any Covered Services Molina covers and a Member's obligation to provide information to Molina about anyone who may be financially responsible for the Covered Services the baby (or babies) receive.

Travel and Lodging Expenses: Travel and lodging expenses are not covered. Molina may pay certain expenses that Molina preauthorizes in accordance with Molina's travel and lodging guidelines. Molina's travel and lodging guidelines are available from Member Services.

CLAIMS

Filing a Claim: Members or Providers must promptly submit to Molina claims for Covered Services rendered to Members. All claims must be submitted in a form approved by Molina and must include all medical records pertaining to the claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by the Member or Provider to Molina within 365 calendar days after the following have occurred:

- Discharge for inpatient services or the date of service for outpatient services; and
- Provider has been furnished with the correct name and address for Molina.

If Molina is not the primary payer under coordination of benefits or third-party liability, the Provider must submit claims to Molina within 30 calendar days after final determination by the primary payer. Except as otherwise provided by State Law, any claims that are not submitted to Molina within these timelines are not be eligible for payment and Provider waives any right to payment.

Claim Processing: Claims payment will be made to Participating Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Molina have agreed in writing to an alternate payment schedule, Molina will pay the Provider of service within 30 calendar days after receipt of a claim submitted with all relevant medical documentation and that complies with Molina billing guidelines and requirements. The receipt date of a claim is the date Molina receives either written or electronic notice of the claim.

Molina Payment: Some Participating Providers receive a flat amount for each month that a Member is under their care, whether they see the Participating Provider or not. Some Providers work on a fee-for-service basis, which means they receive payment for each service they perform. Some Providers may receive incentives for giving quality preventive care. Molina does not provide financial incentives for utilization management decisions that could result in authorization denials or under-utilization. For more information about how Providers are paid, Members may call Member Services. Members may also call a Provider's office or medical group for this information.

Reimbursement: With the exception of any required Cost Sharing amounts, if a Member has paid for a Covered Service or prescription that was approved or does not require approval, Molina will repay the Member. The Member must submit the claim for reimbursement within 12 months from the date they made the payment. Members must mail this information to Molina Member Services at the address on the first page of this Agreement. The Member will need to mail Molina a copy of the bill for the Covered Services from the Provider or facility and a copy of the receipt. The Member should also include the name of the Member for whom they are submitting the claim and their policy number. If the bill is for a prescription, the Member will need to complete a Reimbursement Form. Include a copy of the prescription label and pharmacy receipt when submitting this form to the address as instructed in the form.

After Molina receives the request for reimbursement, Molina will respond to the Member within 30 calendar days. If the claim is accepted, Molina will mail a check to the Member to reimburse the Member. If the claim is denied, Molina will send the Member a letter explaining why the claim was denied. If the Member does not agree with the denial, the Member may file an appeal as described in this Agreement.

Paying Bills: Members should refer to their Schedule of Benefits for their Cost Sharing responsibilities for Covered Services. Members may be liable to pay full price for services when:

- The Member asks for and gets medical services that are not Covered Services.
- Except in the case of Emergency Services or exceptions listed in the "Access to Care" section of this Agreement, the Member asks for and gets healthcare services from a Provider or facility that is not a Participating Provider.

If Molina fails to pay a Participating Provider for providing Covered Services, the Member will not be responsible for paying the Participating Provider for any amounts owed by Molina. This does not apply to Non-Participating Providers.

LEGAL NOTICES

Third Party Liability: Molina is entitled to reimbursement for any Covered Services provided for a Member under this plan to treat an injury or illness caused by the wrongful act, omission, or negligence of a third party, if a Member has been made whole for the injury or illness from the third party or their representatives. Molina shall be entitled to payment, reimbursement, and subrogation (recover benefits paid when other insurance provides coverage) in third party recoveries and the Member shall cooperate to fully and completely assist in the protection the rights of Molina, including providing prompt notification of a case involving possible recovery from a third party. Members must reimburse Molina for the reasonable cost of services paid by Molina to the extent permitted by State law immediately upon collection of damages by the Member, whether by action or law, settlement or otherwise; and fully cooperate with Molina's effectuation of its lien rights for the reasonable value of services provided by Molina to the extent permitted under State law. Molina's lien may be filed with the person whose act caused the injuries, his or her agent, or the court.

Workers' Compensation: Molina will not furnish benefits under this Agreement that duplicate the benefits to which the Member is entitled under any applicable workers' compensation law. The Member is responsible for all action 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's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between the Member and the Workers' Compensation carrier as to a Member's ability to collect under workers' compensation laws, Molina will provide the benefits described in this Agreement until resolution of the dispute. If Molina provides benefits which duplicate the benefits the Member is entitled to under workers' compensation law, Molina will be entitled to reimbursement for the reasonable cost of such benefits.

Renewability of Coverage: Molina will renew coverage for Members on the first day of each month if all Premiums which are due have been received. Renewal is subject to Molina's right to amend this Agreement and the Member's continued eligibility for this Plan. Members must follow all procedures required by the Marketplace to redetermine eligibility and guaranteed renewability for enrollment every year during the Open Enrollment Period.

Changes in Premiums and Cost Sharing: Any change to this Agreement, including, but not limited to, changes in Premiums, Covered Services, Deductible, Copayment, Coinsurance and OOPM amounts, is effective after 60 days' notice to the Subscriber's address of record with Molina.

Acts Beyond Molina's Control: If circumstances beyond the reasonable control of Molina, 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 and the Participating Provider shall provide or attempt to provide Covered Services in so far as practical, according to their best judgment, within the limitation of such facilities and personnel and Participating Providers. Neither Molina 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'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's right to require a Member's performance of any provision of this Agreement.

Non-Discrimination: Molina does not discriminate in hiring staff or providing medical care on the basis of pre-existing health condition, color, creed, age, national origin, ethnic group identification, religion, handicap, disability, sex or sexual orientation and/or gender identity, or genetic information.

Organ or Tissue Donation: The State's Legislature has asked Molina to tell Members that they 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. Members may choose to be an organ tissue donor by contacting the Department of Motor Vehicles to obtain an organ donation card.

Agreement Binding on Members: 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.

Assignment: A Member 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. Consent may be refused in Molina's discretion.

Governing Law: Except as preempted by federal law, this Agreement will be governed in accordance with State law and any provision that is required to be in this Agreement by state or federal law shall bind Molina 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, 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 under this Agreement will be sent to the most recent address or record for the Subscriber. The Subscriber is responsible for reporting any change in address to the Marketplace.

Subrogation for a Surrogacy Arrangement: If a Member enters into a Surrogacy Arrangement and the Member or any other payee is entitled to receive payments or other compensation under the Surrogacy Arrangement, the Member must reimburse Molina for Covered Services the Member receives 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 the Member's obligation or pay the Member's Copayment or Coinsurance for these Covered Services. After the Member surrenders a baby to the legal parents, the Member is 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, the Member automatically assigns to Molina the Member's right to receive payments that are payable to the Member or any other payee under the Surrogacy Arrangement, regardless of whether those payment are characterized as being for medical expenses. To secure Molina's rights, Molina 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 Molina's lien. The assignment and Molina's lien will not exceed the total amount of the Member's obligation to Molina under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, the Member 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 Molina requests in order to satisfy Molina's rights

The Member must send this information to the address on the first page of this Agreement.

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

If the Member's estate, parent, guardian or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the Member's estate, parent, guardian, or conservator shall be subject to Molina's liens and other rights to the same extent as if the Member had asserted the claim against the third party. Molina may assign Molina's rights to enforce Molina's liens and other rights.

If the Member has questions about the Member's obligations under this provision, please contact Member Services.

Wellness Program and Other Program Benefits: This Agreement includes access to a wellness program offered to encourage Members to complete health activities that support their overall health. The program is voluntary and available to all Subscribers at no cost. The program is additionally available to Dependents 18 years and older at no cost. Molina may offer Members rewards or other benefits for participating in certain health activities and programs. The rewards and program benefits available to Members may include premium credits or other benefits such as gift cards.

Members should consult with their PCP before participation. The wellness program is optional, and the benefits are made available at no additional cost to eligible members. For more information, please contact Member Services.

Health Education Materials: Molina provides easy-to-read materials on topics such as nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, and diabetes. To get these materials, Members may visit www.MolinaMarketplace.com.

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 Members change certain aspects of their lifestyle. They will show Members how to eat healthier, reduce stress, and get more physical activity. The program also includes group support from others who share 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 a Member begins to eat better and becomes more active, the Member will notice changes. The changes may be in how the Member feels or even in how the Member looks. The DPP staff will work with Members to see if they 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 their provider or by calling Member Services.

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, 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 agree that, by entering into the agreement enrolling Member in this product, Member and Molina are each waiving the right to a trial by jury or to participate in a class action. Member and Molina 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 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 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.

APPEALS AND GRIEVANCES

Complaint or Grievance: A complaint is a grievance. A grievance is a written or oral expression of dissatisfaction that a Member has 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 a Member or a Member's representative. For example, a Member may be dissatisfied with the hours of availability of a 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.

If a Member has a problem with any Molina services including Pediatric Dental Services, Molina wants to help fix it.

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

- By phone at the Molina Member Services number on page 2 of this Agreement.
- In writing by mail or filing online at the following:
  Attn: CA Appeals and Grievance Coordinator
  Molina Healthcare, Inc
  PO Box 31336
  Salt Lake City, UT 84131
  MolinaMarketplace.com
- By sending an email to:
  Member_Appeals_MolinaHC_NW@Molinahealthcare.com
- By faxing 1 (888) 444-1126

Members may also call the California State Department of Managed Health Care (DHMC) toll-free at 1 (888) 466-2219).

Molina recognizes the fact that Members may not always be satisfied with the care and services provided by Molina's contracted doctors, hospitals and other providers. Molina wants to know about Member problems and complaints.

Members may file a grievance (also called a complaint) in person, in writing, or by telephone as described above.

Molina will send a letter acknowledging receipt of a Member's grievance within 5 calendar days and will then issue a formal response within 30 calendar days of the date of the Member's initial contact with Molina. All levels of grievances will be resolved within 30 calendar days.

If a Member is not satisfied with Molina's response to a grievance, the Member may be able to file an appeal with Molina if it is received and can be processed within 30 calendar days of the initial receipt of the grievance. Molina will send a letter acknowledging receipt of the appeal within 5 calendar days. All levels of Molina's appeals and grievances procedures will be completed within 30 calendar days.

Members must file a grievance within 180 calendar days from the day the incident or action occurred which caused the Member to be unhappy.

A Member's coverage will remain in effect pending the outcome of the internal appeal.

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

Nonformulary External Exception Review: If a Member disagrees with the denial of a "nonformulary drug" and/or step therapy exception request, the Member, the Member's representative, or the Member's 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 "Appeals and Grievances" 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:

- 24 hours following receipt of an expedited exception request
- 72 hours following receipt of a standard exception request

Department of Managed Health Care Assistance

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 (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 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 (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Independent Medical Review: A Member may request an independent medical review ("IMR") of a Disputed Healthcare Service from the Department of Managed Health Care ("DMHC") if the Member believes that healthcare services have been improperly denied, modified, or delayed by Molina 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 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 Members. Members pay no application or processing fees of any kind for IMR. Members have the right to give information in support of the request for an IMR. Molina will give Members 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 a Member to lose any statutory right to take legal action against Molina regarding the disputed healthcare service.

Eligibility for IMR: A Member's application for an IMR will be reviewed by the DMHC to confirm that:

1. Either:
    A. The Member's provider has recommended a healthcare service as Medically Necessary, or
    B. The Member has received Urgent Care or Emergency Services that a provider determined to be Medically Necessary, or
    C. The Member has been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which the Member seeks medical review;

2. The Disputed Healthcare Service has been denied, modified, or delayed by Molina 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. The Member filed a grievance with Molina or its Participating Provider, and the disputed decision is upheld, or the grievance remains unresolved after 30 calendar days. The Member is not required to wait for a response from Molina for more than 30 calendar days.

   If a grievance requires Expedited Review the Member may bring it immediately to the DMHC's attention. The Member is not required to wait for a response from Molina for more than 3 calendar days. The DMHC may waive the requirement that Members follow Molina's grievance process in extraordinary and compelling cases.

If a 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. The Member will get a copy of the assessment made in the case. If the IMR determines the service is Medically Necessary, Molina will provide the healthcare service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within 30 calendar days of receipt of the Member's application and supporting documents. For urgent cases involving an imminent and serious threat to a Member's 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 the Member's health, the IMR organization must provide its determination within 3 calendar days.

For more information regarding the IMR process, or to request an application form, please call Molina Member Services.

Independent Medical Review for Denials of Experimental/Investigational Therapies: Members may also be entitled to an Independent Medical Review of Molina's decision to deny coverage for treatment that Molina has determined to be Experimental or Investigational.

- The treatment must be for a life-threatening or seriously debilitating condition.
- Molina will notify the Member in writing of the opportunity to request an Independent Medical Review of a decision denying an Experimental/ Investigational therapy within 5 business days of the decision to deny coverage.
- A Member is not required to participate in Molina's grievance process prior to seeking an Independent Medical Review of Molina's decision to deny coverage of an Experimental/ Investigational therapy.
- The Independent Medical Review will be completed within 30 calendar days of the Department of Managed Health Care's receipt of a Member's application and supporting documentation. If a Member's doctor determines that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within 7 calendar days of the completed request for an expedited review.

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 تستخدم اللغة العربية، تتاح خدمات المساعدة اللغوية، مجاناً، لك. اتصل بقسم خدمات الأعضاء. ورقم الهاتف هذا موجود خلف بطاقة تعريف 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 ទំហំអក្សរធំដោយសារតែតម្រូវការជាពិសេសរបស់អ្នក ឬជាភាសារបស់អ្នកដោយមិនគិតតម្លៃបន្ថែមឡើយ។
(Cambodian)

ADDENDUM FOR 2023
PEDIATRIC DENTAL ADDENDUM

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.

"Annual Out-of-Pocket Maximum" (also referred to as "OOPM"): means the most a Member must pay for Covered Services in a Plan year. After a Member spends this amount on deductibles, copayments, and coinsurance, CDN pays 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members. Amounts the Subscriber or Dependents pay for services not covered by this Plan do not count towards the OOPM. The Schedule of Benefits may list an OOPM amount for each individual enrolled 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 Dependent, when that person meets the individual OOPM amount; or 2) the family OOPM will be met when a Member's family's Cost Sharing adds up to the family OOPM amount. Once the total Cost Sharing for the Subscriber or a Dependent adds up to the individual OOPM amount, CDN will pay 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members for the rest of the plan year for the pediatric enrollee. Once the cost sharing for two or more Member's family adds up to the family OOPM amount, CDN will pay 100% of the costs of Covered Dental Essential Health Benefits for pediatric (children up to age 19) Members for the rest of the plan year for the Member and every pediatric (children up to age 19) Member of their family.

"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.
Interpretation services are available to members at all points of contact, including when a member is accompanied by a family member or friend who can provide interpretation services, at no cost to the member. To arrange for interpreter services at your dental appointment or other point of contact please contact the CDN member services department.

DISCLOSURE AND CONFIDENTIALITY OF INFORMATION

All personal and medical records (including any personal or privileged information, medical records, patient charts, etc.) shall remain confidential. Such confidential information may be reviewed by CDN as required by its staff and Quality Assurance Committee.

Such 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 is required to be signed by the patient, along with the appropriate fee, as allowed by law, before any records will be released. CDN will respond to such a request within 30 days after receipt of the appropriate executed forms and fees.

CDN subscribers and enrollees may request confidential communication by direct mail or through electronic communication. Mail requests to:

California Dental Network, Inc
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653
or Phone:
(949) 830-1600: Toll-Free (877) 425-4164

CDN will implement confidential communications requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail.

CDN does not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.

CDN does not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.

CDN permits and accommodates requests for confidential communications in the form and format requested by the protected individual, if readily producible in the requested form and format, or at alternative locations.

The confidential request will be valid until the subscriber or enrollee submits a revocation of request or a new confidential communication request is submitted. The confidential communication request will apply to all communications that disclose medical information or provider name and address related to the receipt of medical services by the individual requesting the confidential communication.

CDN'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 Participating Dentist who has custody of the records. Should the Participating Dentist deny Member the request to add an addendum, the Member should contact CDN for assistance.

A STATEMENT DESCRIBING CDN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

TELEDENTISTRY

This plan includes coverage for dental services appropriately delivered through teledentistry services. In general, teledentistry can be used to make basic diagnoses, triage emergencies, and

answer oral care questions. During a virtual visit, your dentist might determine that you need to be seen now for emergency care or decide you can wait until after regular in-office appointments resume. Services are covered on the same basis and to the same extent that the same service through in-person diagnosis, consultation, or treatment is covered. Coverage is not limited only to services delivered by select third-party corporate telehealth providers.

BENEFITS, EXCLUSIONS, AND LIMITATIONS

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

CDN monitors out-of-pocket payments over the course of the plan year. CDN will provide the pediatric enrollee with their balance accrued toward their annual deductible and annual OOPM for every month in which benefits were used and until the annual balance equals the full OOPM amount. Pediatric enrollees may request their most up-to-date accrual balance toward their annual OOPM from us at any time. When those payments reach the Out-of-Pocket Maximum for a member's plan, we will send a letter to both the member and the member's selected Participating Dentist to ensure that they are not responsible for copayments for future services.

Accrual updates shall be mailed to enrollees unless the enrollee has elected to opt out of mailed notice and elected to receive the accrual update electronically, or unless the enrollee has previously opted out of mailed notices.

- Enrollees who have opted out of receiving mailed notice may opt back in at any time.
- Accrual updates may be included with evidence of benefit statements.

CDN subscribers and enrollees may request confidential communication by direct mail or through electronic communication. Mail requests to:
California Dental Network, Inc
23291 Mill Creek Drive, Suite 100
Laguna Hills, CA 92653

or Phone:
(949) 830-1600: Toll-Free (877) 425-4164

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.

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.
- 2D oral/facial photographic image obtained intra-orally or extra-orally (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). 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). 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-cement or re-bond bilateral space maintainer-maxillary (D1551): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.
- Re-cement or re-bond bilateral space maintainer-mandibular (D1552): A benefit once per provider, per applicable quadrant or arch; for patients under the age of 18.
- Re-cement or re-bond unilateral space maintainer-per quadrant (D1553): 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 – permanent tooth (D2928): 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.
- 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 (including retentive/clasping materials, 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 (including retentive/clasping materials any 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.
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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 crown - porcelain fused to high noble alloys (D6066): See D6010
- Implant supported metal crown (high noble alloys) (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 FPD - porcelain fused to high noble alloys (D6076): See D6010
- Implant supported retainer for metal FPD high noble alloys (D6077): See D6010
- Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis (D6080): See D6010
- Implant supported crown (porcelain fused to predominately base alloys (D6082): See D6010
- Implant supported crown (porcelain fused to noble alloys (D6083): See D6010
- Implant supported crown (porcelain fused to titanium and titanium alloys) (D6084): See D6010Implant supported crown (predominately base alloys (D6086): See D6010
- Implant supported crown (noble alloys (D6087): See D6010
- Implant supported crown (titanium and titanium alloys) (D6088): See D6010
- Repair implant supported prosthesis, by report (D6090): See D6010
- Replacement of replaceable part 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
- Abutment supported crown - porcelain fused to titanium and titanium alloys (6097): See D6010
- Implant supported retainer - porcelain fused to predominantly base alloys (D6098): See D6010
- Implant supported retainer for FPD - porcelain fused to noble alloys (6099): See D6010
- Implant supported retainer – porcelain fused to titanium and titanium alloys (6120): See D6010
- Implant supported retainer for metal FPD – predominantly base alloys (6121): See D6010
- Implant supported retainer for metal FPD – noble alloys (6122): See D6010
- Implant supported retainer for metal FPD – titanium and titanium alloys (6123): 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, D6784 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, D6784 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, D6784 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, D6784 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.

- Retainer crown ¾ - titanium and titanium alloys (D6784): 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.

- Buccal / labial frenectomy (frenulectomy) (D7961): A benefit once per arch per date of service; only when the permanent incisors and cuspids have erupted.
- Lingual frenectomy (frenulectomy) (D7962): 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 maxillary (D8696): 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.
- Repair of orthodontic appliance mandibular (D8697): 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.
- Re-cement or re-bond fixed retainer – maxillary (D8698): A benefit for patients under the age of 21; once per provider.
- Re-cement or re-bond fixed retainer – mandibular (D8699): A benefit for patients under the age of 21; once per provider.
- Repair of fixed retainer, includes reattachment – maxillary (D8701): A benefit for patients under the age of 21; once per provider.
- Repair of fixed retainer, includes reattachment – mandibular (D8702): A benefit for patients under the age of 21; once per provider.
- Replacement of lost or broken retainer – maxillary (D8703) 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
- Replacement of lost or broken retainer – mandibular (D8704) A benefit: for patients under the age of 21; once per arch; only within 24 months following the date of service of orthodontic retention

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 (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS

	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
Diagnostic		
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	2D oral/facial photographic image obtained intra-orally or extra-orally	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
D0701	Panoramic radiographic image – image capture only	No Charge
D0702	2-D cephalometric radiographic image – image capture only	No Charge
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only	No Charge
D0704	3-D photographic image – image capture only	No Charge
D0705	Extra-oral posterior dental radiographic image – image capture only	No Charge
D0706	Intraoral – occlusal radiographic image – image capture only	No Charge
D0707	Intraoral – periapical radiographic image – image capture only	No Charge
D0708	Intraoral – bitewing radiographic image – image capture only	No Charge
D0709	Intraoral – complete series of radiographic images – image capture only	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge
Preventive		
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
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	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
D1355	Caries preventive 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
D1551	Re-cement or re-bond bilateral space maintainer-maxillary	No Charge
D1552	Re-cement or re-bond bilateral space maintainer- mandibular	No Charge
D1553	Re-cement or re-bond unilateral space maintainer- per quadrant	No Charge
D1556	Removal of fixed unilateral space maintainer-per quadrant	No Charge
D1557	Removal of fixed space maintainer-maxillary	No Charge
D1558	Removal of fixed space maintainer-mandibular	No Charge
D1575	Distal shoe space maintainer – fixed – unilateral, per quadrant	No Charge
Restorative		
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
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$120
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 customize a crown to fit under an existing partial denture framework	$35
D2980	crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
Endodontics		
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
D3430	retrograde filling - per root	$90
D3471	Surgical repair of root resorption - anterior	$160
D3472	Surgical repair of root resorption - premolar	$160
D3473	Surgical repair of root resorption - molar	$160
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3999	Unspecified endodontic procedure, by report	$100
Periodontics		
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, per site.	$80
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	$40
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
Prosthodontics, Removable		

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 (including retentive/clasping materials, rests, and teeth)	$300
D5212	mandibular partial denture - resin based (including retentive/clasping materials, rests, and teeth)	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials any conventional clasps, rests and teeth)	$335
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)	$275
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, 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
Maxillofacial Prosthetics		
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
Implant Services		
D6010	Surgical placement of implant body: endosteal implant	$350
D6011	Surgical access to an implant body (second stage implant surgery)	$350

D6013	Surgical placement of mini implan	$350
D6040	Surgical placement: eposteal implant	$350
D6050	Surgical placement: transosteal implant	$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 crown - porcelain fused to high noble alloys	$335
D6067	Implant supported crown (high noble alloys)	$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 FPD (porcelain fused to high noble alloys)	$330
D6077	Implant supported retainer for metal FPD (high noble alloys)	$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
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335
D6083	Implant supported crown - porcelain fused to noble alloys	$335
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335
D6085	Provisional implant crown	$300
D6086	Implant supported crown - predominantly base alloys	$340
D6087	Implant supported crown - noble alloys	$340
D6088	Implant supported crown - titanium and titanium alloys	$340
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of replaceable part 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
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315

D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330
D6100	Surgical removal of implant body	$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
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys	$330
D6121	Implant supported retainer for metal FPD – predominantly base alloys	$350
D6122	Implant supported retainer for metal FPD – noble alloys	$350
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6191	Semi-precision abutment – placement	$350
D6192	Semi-precision attachment – placement	$350
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315
D6199	Unspecified implant procedure, by report	$350
Prosthodontics, Fixed		
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
D6784	Retainer crown ¾ - titanium and titanium alloys	$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
Oral Maxillofacial Surgery		
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
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80
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
D7961	Buccal / labial frenectomy (frenulectomy)	$120
D7962	Lingual frenectomy (frenulectomy)	$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
Orthodontics		
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	
D8696	Repair of orthodontic appliance – maxillary	
D8697	Repair of orthodontic appliance – mandibular	

D8698	Re-cement or re-bond fixed retainer – maxillary	
D8699	Re-cement or re-bond fixed retainer – mandibular	
D8701	Repair of fixed retainer, includes reattachment – maxillary	
D8702	Repair of fixed retainer, includes reattachment – mandibular	
D8703	Replacement of lost or broken retainer – maxillary	
D8704	Replacement of lost or broken retainer – mandibular	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive General Services		
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
D9950	Occlusion analysis – mounted case	$120
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$210
D9997	Dental case management - patients with special health care needs	No Charge
D9999	unspecified adjunctive procedure, by report	No Charge

Endnotes to 2023 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.