Enrollment, Eligibility and Disenrollment

Enrollment in Michigan

The Michigan Marketplace is the program which implements the Health Insurance Marketplace as part of the Affordable Care Act. It is administered by the Department of Insurance and Financial Services.

To enroll with Molina Healthcare, the member, his/her representative, or his/her responsible parent or guardian must follow enrollment process established by Michigan's program. The Department of Insurance and Financial Services will enroll all eligible members with the health plan of their choice.

No eligible member shall be refused enrollment or re-enrollment, have his/her enrollment terminated, or be discriminated against in any way because of his/her health status, pre-existing physical or mental condition, including pregnancy, hospitalization or the need for frequent or high-cost care.

Effective Date of Enrollment

Coverage shall begin as designated by the Marketplace Exchange on the first day of a calendar month. If the enrollment application process is completed by the 15th of the month, the coverage will be effective on the first day of the next month. If enrollment is completed after the 15th of the month, coverage will be effective on the first day of the second month following enrollment.

Newborn Enrollment

When a Molina Healthcare Marketplace Subscriber or their Spouse gives birth, the newborn is automatically covered under the Subscriber's policy with Molina Healthcare for the first 31 days of life. In order for the newborn to continue with Molina Healthcare coverage past this time, the infant must be enrolled through the Marketplace Exchange with Molina Healthcare on or before 60 days from the date of birth.

PCP's are required to notify Molina Healthcare via the Pregnancy Notification Report (included in Appendix B of this manual) immediately after the first prenatal visit and/or positive pregnancy test for any Molina Healthcare member presenting themselves for healthcare services.

Inpatient at Time of Enrollment

Regardless of what program or health plan the member is enrolled in at discharge, the program or plan the member is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the member is no longer confined to

an acute care hospital.

Eligibility Verification

Health Insurance Marketplace Programs

Payment for services rendered is based on enrollment status and coverage selected. The contractual agreement between providers and Molina Healthcare places the responsibility for eligibility verification on the provider of services.

Eligibility Listing for Molina Healthcare Marketplace Programs

Providers who contract with Molina Healthcare may verify a member's eligibility for specific services and/or confirm PCP assignment by checking the following:

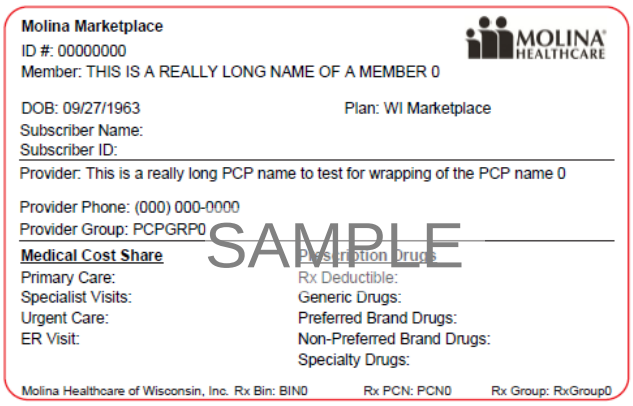
- Molina Healthcare Member Services at 866-898-7969
- Molina Healthcare, Inc., Web Portal website, www.molinahealthcare.com, Provider Services

Possession of a Marketplace ID Card does not mean a recipient is eligible for Marketplace services. A provider should verify a recipient's eligibility each time the recipient presents to their office for services.

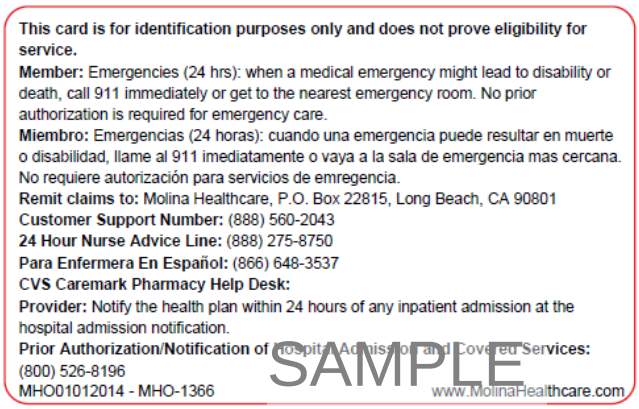
Identification Cards

Molina Healthcare of State, Inc. Sample Member ID card

Card Front



Card Back



Members are reminded in their Member Handbooks to carry ID cards with them when requesting medical or pharmacy services. It is the provider's responsibility to ensure Molina Healthcare members are eligible for benefits and to verify PCP assignment, prior to rendering services. Unless an emergency condition exists, providers may refuse service if the member cannot produce the proper identification and eligibility cards.

Disenrollment

Voluntary Disenrollment

Members have the right to terminate coverage for any reason at any time. However, beyond the open-enrollment period, if a member elects to terminate coverage with Molina Healthcare Marketplace, they are not eligible to re-enroll with another health plan until the following year's open-enrollment period unless there is a life event, and they qualify for a SEP (Special Enrollment Period) or if they are American Indian or Alaska Native. Members may discontinue Molina coverage by calling Molina Member Services at 1-(866) 898-7969.

Voluntary disenrollment does not preclude members from filing a grievance with Molina Healthcare for incidents occurring during the time they were covered.

Involuntary Disenrollment

Under very limited conditions and in accordance with the Marketplace Exchange guidelines, members may be involuntarily disenrolled from a Molina Healthcare Marketplace program. With proper written documentation and approval by the Department of Insurance and Financial Services or its Agent; the following are acceptable reasons for which Molina Healthcare may submit Involuntary Disenrollment requests to the Department of Insurance and Financial Services:

- Delinquency of payment, past defined grace period(s)
- Member has moved out of the Service Area
- Member death
- Member's continued enrollment seriously impairs the ability to furnish services to this member or other members
- Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness (this may not apply to members refusing medical care)
- Member's utilization of services is fraudulent or abusive

Missed Appointments

The provider will document appointments missed and/or canceled by the member. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel. Such a request must be submitted

at least sixty (60) calendar days prior to the requested effective date. The provider agrees not to charge a member for missed appointments.

PCP Assignment

Molina Healthcare will offer each member a choice of PCPs. After making a choice, each member will have a single PCP. Molina Healthcare will assign a PCP to those members who did not choose a PCP at the time of Molina Healthcare selection. Molina Healthcare will take into consideration the member's last PCP (if the PCP is known and available in Molina Healthcare's contracted network), closest PCP to the member's home address, ZIP code location, keeping Children/Adolescents within the same family together, age (adults versus Children/Adolescents) and gender (OB/GYN). Molina Healthcare will allow pregnant members to choose the Health Plan's obstetricians as their PCPs to the extent that the obstetrician is willing to participate as a PCP.

PCP Changes

Members can change their PCP at any time. All changes completed by the 25th of the month will be in effect on the first day of the following calendar month. Any changes requested on or after the 26th of the month will be in effect on the first day of the second calendar month.

Molina Marketplace Grace Period

Summary

The Affordable Care Act (ACA) mandates that all qualified health plans offering insurance through the Health Insurance Marketplace provide a grace period of three (3) consecutive months to APTC Members who fail to pay their monthly premium by the due date. Molina Marketplace also offers a one (1) month grace period to Non-APTC Members who fail to pay their monthly premium by the due date. To qualify for a grace period, the member must have paid at least one full month's premium within the benefit year. The grace period begins on the first day of the first month for which the member's premium has not been paid. The grace period is not a "rolling" period. Once the member enters the grace period, they have until the end of that period to resolve the entire outstanding premium balance; partial payment will not extend the grace period.

Grace Period Timing

Non-APTC Members:

Non-ATPC Members are granted a one (1) month grace period, during which they may be able to access some or all services covered under their benefit plan. If the *full past-due premium* is not paid by the end of the grace period, the Non-APTC Member will be retroactively terminated to the last day of the last month for which the premium was paid.

APTC Members:

APTC Members are granted a three (3) month grace period. During the first month of the grace period claims and authorizations will continue to be processed. Services, authorization requests and claims may be denied or have certain restrictions during the second and third months of the grace period. If the APTC Member's *full past-due premium* is not paid by the end of the third month of the grace period, the APTC Member will be retroactively terminated to the last day of the first month of the grace period.

Service Alerts

Whenever a member is in the grace period, Molina Healthcare will have a service alert on the Web Portal, IVR and in the call centers. This alert will provide more specific detail about where the member is in the grace period (first month vs. second and third) as well as information about how authorizations and claims will be processed during this time. Providers should verify both the eligibility status AND any service alerts when checking the eligibility of a member. For additional information about how authorizations and claims will be processed during this time, please refer to the Member Evidence of Coverage, or contact our Provider Services Department at 855-322-4077.

Notification

All members will be notified upon entering the first month of the grace period. Additionally, when an APTC Member enters the grace period, Molina Healthcare will provide notification to providers who submit claims for services rendered to the APTC Member during the grace period. This notification will advise providers that payment for services rendered during the second and third months of the grace period may be denied if the premium is not *paid in full* prior to the expiration of the third month of the grace period.

Prior Authorizations

Authorization requests received during the first month of a member's grace period will be processed according to medical necessity standards. Authorizations received during the second and third month of the APTC Member's grace period will be denied, due to the suspension of coverage. If the APTC Member pays the full premium payment prior to the expiration of the grace period, providers may then seek authorization for services. If the APTC Member did not receive services during the second or third month of the grace period because the prior authorization was denied, the provider must submit a new authorization request for those services. If the APTC Member received services during the second or third month of the grace period without a prior authorization, the provider may request a retro-authorization for those services already rendered. Retro-authorization requests will be reviewed based on medical necessity.

Claims Processing

First Month of Grace Period: Clean claims received for services rendered during the first month of a grace period will be processed using Molina Healthcare's standard processes and in accordance with state and federal regulations and within established turn-around-times.

Second/Third Month of Grace Period: Clean claims received for services rendered during the second and third months of an APTC Member's grace period will be pended until the premium is paid in full. In the event that the APTC Member is terminated for non-payment of the *full premium* prior to the end of the grace period, Molina Healthcare will deny claims for services rendered in the second and third months of the grace period. Pharmacy claims received will process based on program drug utilization review and formulary edits; the APTC Member will be charged 100% of the discounted cost for prescriptions filled during the second and third months of the grace period.