Molina Healthcare of Idaho
Outline of Coverage

This Managed Care outline of coverage provides a very brief description of important policy features. Please note that this outline is not intended to be part of the insurance contract ("Agreement"). Only the actual provisions of the Agreement are final and binding between the member and Molina. The Agreement itself sets forth in detail the rights and obligations of both the Member and Molina.

Read Your Contract Carefully

Individual Major Medical Expense Coverage: Individual major medical expense coverage is designed to provide, to persons insured, comprehensive coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or illness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayments, coinsurance, or other limitations that may be set forth in the Agreement.

Pediatric Dental Coverage Notice: This Agreement does not include coverage for pediatric dental care, which is considered an essential health benefit under the Affordable Care Act. Pediatric dental care is available in the market and can be purchased as a stand-alone product. Please contact your insurance agent, a stand - alone dental insurance provider or Your Health Idaho if you wish to purchase a stand-alone dental care product.

Molina Healthcare of Idaho
Schedule of Benefits
Silver 1 200 with Adult Vision Services

This Schedule of Benefits is intended to be used to help Members determine coverage of benefits and Cost Share. This Schedule of Benefits is a summary only. The Molina Healthcare of Idaho Agreement and Individual Evidence of Coverage ("Agreement") should be consulted for additional description of benefit, limitation, and exclusion information.

This Plan does not include pediatric dental services as required under the Affordable Care Act. Pediatric dental service coverage is available through the Health Benefit Exchange and can be purchased as a stand-alone product.

In-network Deductible and Maximum Out-of-Pocket amounts accumulate separately from the Out-of-Network Deductible and Maximum Out-of-Pocket amounts. Members actual costs for services provided by an Out-of-Network provider may exceed this Plan's Maximum Out-of-Pocket limit for Out-of-Network services. In addition, Out-of-Network providers can bill Members for the difference between the amount charged by the provider and the Molina's Allowed Amount, and this amount is not counted toward the Out-of-Network Maximum Out-of-Pocket limit. Members should consult their Agreement or contact Molina Customer Support for additional information.

Deductible Type	In-Network Deductible	Out-of-Network Deductible
Medical		
Individual	$3,500	$15,100
Family	$7,000	$30,200
Prescription Drug		
Individual	Combined with Medical Deductible	Combined with Medical Deductible
Family	Combined with Medical Deductible	Combined with Medical Deductible
Maximum Out-of-Pocket Type	**In-Network Maximum Out-of-Pocket**	**Out-of-Network Maximum Out-of-Pocket**
Individual	$6,775	$75,500
Family	$13,550	$151,000
Service	**In-Network Cost Share**	**Out-of-Network Cost Share**
Preventive Services[1]	No Charge	60% Coinsurance after Deductible
[1] Please refer to the Agreement for full information of covered preventive services.		

Emergency/Urgent Care	In-Network Cost Share	Out-of-Network Cost Share
Emergency Room Facility Cost Sharing waived if admitted (Inpatient Cost Sharing applies).	35% Coinsurance after Deductible	35% Coinsurance after Deductible
Emergency Medical Transportation - Ambulance	35% Coinsurance after Deductible	35% Coinsurance after Deductible
Urgent Care	$45	60% Coinsurance after Deductible
Outpatient Professional Services	**In-Network Cost Share**	**Out-of-Network Cost Share**
Office Visits		
Primary Care Provider	$30	60% Coinsurance after Deductible
Other Practitioner	$30	60% Coinsurance after Deductible
Mental Health Services	$30	60% Coinsurance after Deductible
Substance Use Disorder	$30	60% Coinsurance after Deductible
Specialist	$60	60% Coinsurance after Deductible
Mental Health and Substance Use Disorder Outpatient Services		
Mental Health Services	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Substance Use Disorder Services	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Habilitation and Rehabilitation Services[3] (All outpatient places of service)		
Habilitative Services — Limit 20 visits per calendar year for physical, occupational and speech therapy	$30	60% Coinsurance after Deductible
Rehabilitative Services — Limit 20 visits per calendar year or physical, occupational and speech therapy	$30	60% Coinsurance after Deductible
Chiropractic Services — Limit 18 visits per calendar year	$30	60% Coinsurance after Deductible

[3] There are no visit limits for treatment of Autism Spectrum Disorder or related diagnoses.

Outpatient Facility Services	In-Network Cost Share	Out-of-Network Cost Share
Outpatient Facility Fee	35% Coinsurance after Deductible per visit	60% Coinsurance after Deductible
Outpatient Professional Fee	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Accidental Dental	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Specialized Scanning Services (CT Scan, PET Scan, MRI)	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Radiology Services (X-ray)	$95	60% Coinsurance after Deductible
Laboratory Tests	$60	60% Coinsurance after Deductible
Radiation	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Cancer Chemotherapy and Other Provider-Administered Drugs	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Inpatient Services	**In-Network Cost Share**	**Out-of-Network Cost Share**
Inpatient Facility Fee — Medical/Surgical — Maternity/Delivery — Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Inpatient Professional Fee — Medical/Surgical, — Maternity — Mental/Behavioral Health (Inpatient Psychiatric Hospitalization, Substance Abuse, Inpatient Detox, Transitional Residential Recovery Services)	35% Coinsurance after Deductible	60% Coinsurance after Deductible

Skilled Nursing Facility — Limit 30 days per calendar year.	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Skilled Nursing Professional	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Hospice	No Charge	60% Coinsurance after Deductible

Prescription Drugs	In-Network Cost Share	Out-of-Network Cost Share
Preventive Drugs	No Charge	60% Coinsurance after Deductible
Preferred Generic Drugs	$20	60% Coinsurance after Deductible
Preferred Brand Drugs	$65 Copay after Deductible	60% Coinsurance after Deductible
Non-Preferred Drugs	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Specialty Drugs	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Mail-order Prescription Drugs A 90-day supply is offered at two and a half times the 30- day retail prescription Cost Sharing. Depending on tier level this will be either a Copayment or a Coinsurance. **Please note**: Cost Sharing reduction for any prescription brand name drugs with a generic equivalent obtained by the Member 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 the Member's Plan.		
Other Services	**In-Network Cost Share**	**Out-of-Network Cost Share**
Durable Medical Equipment	35% Coinsurance after Deductible	60% Coinsurance after Deductible
Dialysis Services — Applies to facility charges only. This is outpatient cost sharing. For inpatient dialysis, inpatient facility Cost Sharing applies.	$60	60% Coinsurance after Deductible
Nutritional Counseling — Limit to 3 visits per calendar year	No Charge	60% Coinsurance after Deductible

Allergy Testing	$30	60% Coinsurance after Deductible
Home Infusion — Administration Only	No Charge	60% Coinsurance after Deductible
Home Healthcare --- Services must be billed by a Home Healthcare agency that is a Participating Provider. Separate Cost Sharing may apply for other covered benefits delivered in the home setting, e.g. injectable drugs, durable medical equipment, etc.	No Charge	60% Coinsurance after Deductible
Family Planning	No Charge	60% Coinsurance after Deductible
Pediatric Vision Services (for Members under age 19 only)		
Comprehensive Vision Exam (Exam limited to one each calendar year.)	No Charge	60% Coinsurance after Deductible
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 lenses every calendar year • Single vision, lined bifocal, lined trifocal, lenticular lenses, polycarbonate lenses All lenses include scratch resistant coating, and ultraviolet protection (UV)	No Charge	60% Coinsurance after Deductible
Prescription Contact Lenses – One calendar year supply In lieu of prescription glasses, prescription contact lenses covered		

with a minimum three-month supply for any of the following modalities every calendar year: • Standard (one pair annually) • Monthly (six-month supply, 2 times per calendar year) • Bi-weekly (three-month supply, 4 times per calendar year) • Dailies (three-month supply, 4 times per calendar year) Medically necessary contact lenses for specified medical conditions require Prior Authorization.	No Charge	60% Coinsurance after Deductible
Adult Routine Vision Services (for Members age 19 and older) Services must be provided by a participating VSP Provider.		
Comprehensive Vision Exam Limited to 1 each calendar year	No Charge	60% Coinsurance after Deductible
Routine Retinal Screening	$39	60% Coinsurance after Deductible
Prescription Glasses Frames: • Limited to 1 pair of frames every calendar year (up to a $150 allowance) Lenses: • Limited to 1 pair every calendar year • Glass or plastic single vision, lined bifocal, lined trifocal or lenticular lenses	No Charge	60% Coinsurance after Deductible
Prescription Contact Lenses (In lieu of prescription glasses, materials and services are limited to 1 pair of contact lenses up to	No Charge	60% Coinsurance after Deductible

$150 every calendar year. Medically Necessary contact lenses for specified medical conditions require Prior Authorization.)		

Exclusions

This section lists specific items and services excluded from coverage under this Agreement. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Covered Services" section.

Acupuncture: Acupuncture is not covered.

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

Bariatric Surgery: Bariatric surgery for weight loss is not covered. Complications that occur as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure that result in an inpatient stay or an extended inpatient stay, as determined by Molina, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous Molina Plan. This exclusion also applies if the surgery was performed while the Member was covered by a previous insurer or self-funded product prior to coverage under this Agreement

Certain Exams and Services: The following are not covered unless a 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.

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 medically necessary reconstructive services specifically covered in any section of this Agreement, including breast reconstruction following a mastectomy.

Dental Services: Molina does not cover routine adult dental services. Pediatric dental services can be purchased as a stand-alone product through the Health Benefit Exchange.

Digital Health and Digital Therapeutics: Mobile applications, software, or hardware devices marketed as digital therapeutics to prevent, manage, or treat medical disorders or behavioral conditions are not covered. This does not apply to formulary continuous glucose monitors or covered insulin pump devices, which are considered durable medical equipment, and are subject to Prior Authorization.

Dietitian: A service of a Dietitian is not a Covered Service except for when covered under the nutritional counseling benefit or Hospice Care benefit. Please consult the Schedule of Benefits for additional details.

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 Drugs: Molina does not cover drugs or treatment for erectile dysfunction.

Experimental or Investigational Services: Any medical service including procedures, medications, facilities, and devices that Molina has determined have not been demonstrated as safe or effective compared with conventional medical services. In determining whether services are Experimental or Investigational, Molina will consider whether the services are in general use in the medical community in the State of Idaho, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

This exclusion does not apply to any of the following:

- Services covered under "Approved Clinical Trials" in the Covered Services section of this Agreement.

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

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

Hearing Aids: The following are not covered: hearing aids, auditory osseointegrated (bone conduction) devices, cochlear implants and examination for or fitting of them, except for congenital or acquired hearing loss that without intervention may result in cognitive or speech development deficits of a covered dependent child, covering not less than one (1) device every thirty-six (36) months per ear with loss and not less than forty-five (45) language/speech therapy visits during the first twelve (12) months after delivery of the covered device

Homeopathic and Holistic Services: Non-traditional services including, but not limited to, holistic and homeopathic treatment, yoga, Reiki, and Rolf therapy are not covered.

Infertility Services: Molina does not cover infertility services and supplies, including insemination and conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Intermediate Care: Care in a licensed intermediate care facility is not covered. This exclusion does not apply to services covered under Durable Medical Equipment, Home

Healthcare, Skilled Nursing Facility Care and Hospice Care in the Covered Services sections of this Agreement.

Long-Term Care and Custodial Nursing Care: Molina does not cover long-term care or custodial nursing care. Assistance with activities of daily living is 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.

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,
- Teaching skills for employment or vocational purposes,
- Vocational training or teaching vocational skills,
- Professional-growth courses,
- Training for a specific job or employment counseling,
- Aquatic therapy and other water therapy
- Examinations related to job, athletic (sports physicals) or recreational performance.

Male Condoms: Male condoms are not covered except those on formulary for women's health preventative services.

Non-Emergent Services Obtained in an Emergency Room: Services provided within an emergency room by a Participating or Non-Participating Provider, which do not meet the definition of Emergency Services, are not covered.

Oral Nutrition: Outpatient oral nutrition is not covered, such as dietary or nutritional supplements, specialized formulas, supplements, herbal supplements, weight loss aids, formulas, and food. Please consult the Phenylketonuria (PKU) and other Inborn Errors of Metabolism section of this document for exceptions.

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 Care 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.

Routine Foot Care Items and Services: Routine foot care items and services are not covered, except for Members with diabetes.

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. Please refer to the Appeals and Grievances section for information about denied requests for Experimental or Investigational services.

Services Provided Outside the Service Area: Except as otherwise provided in this Agreement, 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. Molina does not cover Emergency Services outside of the United States. When death occurs outside the United States, the medical evacuation and repatriation of remains is not covered. Please contact Customer Support for more information.

Services Provided Outside the United States: Molina does not cover services performed outside of the United States, including Emergency Services.

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.

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. If a Member later suffers a life-threatening complication such as a serious infection, this exclusion will not apply. Molina would cover any services that Molina would otherwise cover to treat that complication.

Sexual Dysfunction: Treatment of sexual dysfunction, regardless of cause, including but not limited to devices, implants, surgical procedures, and medications, are not covered.

Surrogacy: Services for anyone in connection with a surrogacy arrangement are not covered, except for otherwise Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Temporomandibular Joint Syndrome (TMJ): Molina does not cover the following services to treat temporomandibular joint syndrome (also known as "TMJ")

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

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.

Weight Loss Programs: Weight loss programs are not covered.

General Provisions

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 Health Benefit Exchange 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. Coverage for a former Member ends at 11:59 p.m. Mountain time on the day before the termination date. If Molina terminates a Member for any reason, the Member must pay all amounts payable related to their coverage with Molina, including Premiums, for the period prior to the termination date. Except in the case of fraud or intentional misrepresentation, if a Member's coverage is terminated, any Premium payments received on account 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 thirty (30) 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 or intentional misrepresentation.

Molina may terminate or not 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 Health Benefit Exchange and Molina due to their age. Please refer to the "Discontinuation of Dependent Coverage" 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 Health Benefit Exchange and Molina. The Health Benefit Exchange 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. Mountain time 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

Fraud or Intentional Misrepresentation: 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. Mountain time 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.

Member Disenrollment Request: Member requests disenrollment to the Health Benefit Exchange. The Health Benefit Exchange will determine the coverage end date.

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 ninety (90) calendar days before the date the coverage will be discontinued.

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

Termination Notification for Non-Payment: Molina will send written notification to a Subscriber informing them when their membership and the membership of their Dependents ended due to non-payment of Premiums. Members may appeal a termination decision by Molina. Please refer to the MolinaMarketplace.com website, the Grievances and Appeals section of this Agreement, or contact Customer Support for more information of how to file an appeal.

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 Health Benefit Exchange.

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 in 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.

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. No agent of Molina has authority to change this Agreement and incorporated documents or to waive any of its provisions.

Change of beneficiary: The right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the policy or to any change of beneficiary or beneficiaries of any other changes in the Agreement