HealthChoice Illinois

Molina Healthcare of Illinois Member Handbook

Effective Date: March 8, 2023

Member Services: (855) 687-7861
(TTY/TDD: 711)

MOLINA® HEALTHCARE

HealthChoice Illinois
Illinois Department of Healthcare and Family Services

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Welcome to the Molina Healthcare of Illinois family.

Intro to plan:

Welcome to Molina Healthcare HealthChoice Illinois! We are committed to treating you and your family with respect and are committed to getting you the care you need.

You are now a Member of Molina Healthcare. Molina Healthcare is a health care plan, also known as a Managed Care Organization (MCO) that covers services for those in an Illinois Medical Assistance program. With Molina Healthcare, you get 24-hour health care coverage at no cost to you.

This handbook will tell you about your benefits. Please read it carefully. It explains:

- How to get health care services
- The extra benefits you get as a Member of Molina Healthcare
- Contact information so that you know who to call

If you need this handbook in Spanish or another prevalent language or format, call Member Services. We can provide materials in another language or format. Tell us what you need, and we will help you.

To learn more, visit our website at MolinaHealthcare.com. You can also call Member Services at **(855) 687-7861 (TTY: 711)** staff is available to help you 8 a.m. to 5 p.m. Monday to Friday.

Si usted tiene cualquier problema para leer o comprender esta o cualquier otra información de Molina Healthcare por favor, comuníquese con el Departamento de Servicios para Miembros de Molina Healthcare al (855) 687-7861 para recibir ayuda.

Important phone numbers & contacts:

Visit us on our website at MolinaHealthcare.com for current information.

Member services

(855) 687-7861
TTY/Illinois Relay Service: 711

24-hour nurse advice line

English: (888) 275-8750
Español: (866) 648-3537
TTY/Illinois Relay Service: 711

24-hour behavioral health crisis line

English: (888) 275-8750
Español: (866) 648-3537
TTY/Illinois Relay Service: 711

Transportation

(844) 644-6354 for reservations and day of ride assist
TTY/Illinois Relay Service: 711

Care coordination

(855) 687-7861
TTY/Illinois Relay Service: 711

Health management department

(866) 891-2320
TTY/Illinois Relay Service: 711

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Member services:

Welcome to Molina Healthcare!

If you have questions, call Molina Healthcare Member Services. Our Member Services Department is ready to help you get the most from your health plan.

You can call Member Services at (855) 687-7861 from 8 a.m. to 5 p.m. Monday through Friday. For those who are deaf or hard of hearing, please call Illinois Relay Service TTY: 711. Member Services can help you if you need to file a complaint, ask a question or need information about services.

Member Services can help you:

- Understand your benefits
- Update your contact information
- Request a new ID card
- Pick a new a primary care provider (PCP)
- Get a copy of this handbook or any Molina Healthcare print material in another language or format

Holiday closures

The Molina Healthcare office is closed on the following days:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day – Open 8 a.m. until Noon
- Christmas Day
- New Year's Eve Day – Open 8 a.m. until Noon

A holiday that falls on a Saturday is observed on the Friday before. A holiday that falls on a Sunday is observed the Monday after.

Our 24-Hour Nurse Advice Line is available at, English (888) 275- 8750, Español (866) 648-3537 (TTY: 711), 24 hours a day, seven days a week to answer questions about your health. Nurses are here to help you decide if you need to go to the emergency room, urgent care, or make an appointment with your PCP. They can help answer questions on your benefits after hours.

What you'll find on our website

Visit our website at MolinaHealthcare.com for current information. On our website you can:

- Find a provider, specialist or other in-network facilities near you
- Learn more about your health care benefits
- Get health and wellness information
- View the certificate of coverage and description of coverage
- Read frequently asked questions
- Get a copy of the most recent Member Handbook
- And more

This handbook is also posted at MolinaHealthcare.com.

Member Identification (ID) card:

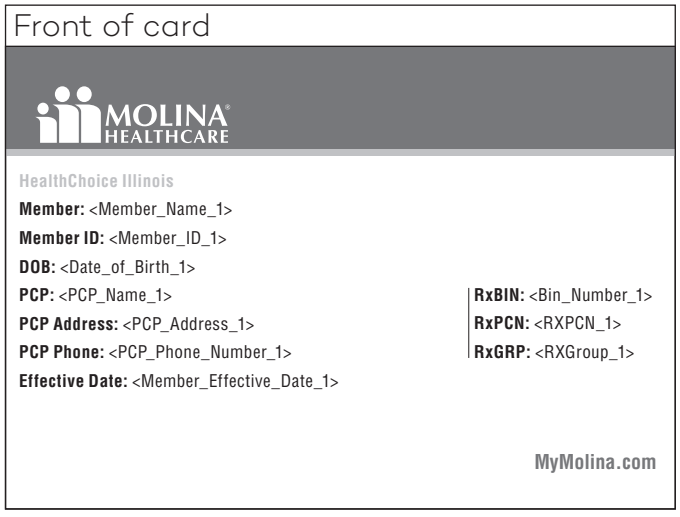
You will get your Molina Healthcare Member ID card in the mail. Keep this card with you at all times. This card replaces your HFS medical card. This card is good for as long as you are a Molina Healthcare Member. It has important phone numbers. You will need to show it when you get services.

Please check your ID card to make sure the information on it is correct.

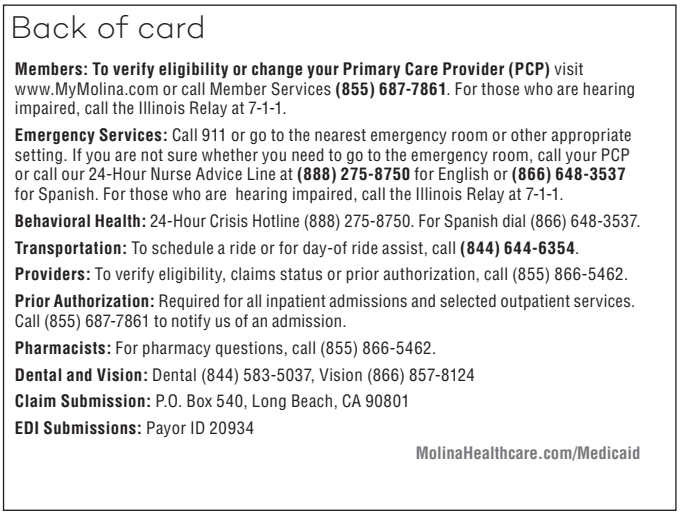
Information on you member ID card:

- Your name
- Plan Name
- Your date of birth (DOB)
- Your State Medicaid identification number (ID#)
- PCP information (name, phone number)
- Effective Date
- Member Services #
- 24 hour Nurse Hot Line
- Behavioral health #
- Dental #
- Transportation #
- Rx, Rx Bin, Rx Group,
- Name & Address of MCO
- Claim Submission P.O. Box 540, Long Beach, CA, 90801

Front of card



Back of card



Check to make sure the information on your card is correct. If anything on your card is wrong, visit MyMolina.com to update your records. If the PCP on your ID card is not the PCP you are seeing or if you would like to see a different PCP, you can update at MyMolina.com. Visit MyMolina.com to print a temporary ID card and request a new ID card. You may also call Member Services for help. Your PCP must be an in-network provider. Our network providers are listed online in our provider directory. If you do not have your Member ID card yet, call Member Services.

Open enrollment:

Annual open enrollment period
After one year of enrollment, you can change your health plan if you want to. You don't have to do anything if you want to stay with Molina Healthcare.

You will be contacted before your anniversary date of enrollment, you will get a letter from Illinois Client Enrollment Services (ICES). The letter will state you can choose another health plan if you want. The letter will include the dates you can make changes and steps on how to change. After you get the letter, you will have a limited time to make a change. This is called "Open Enrollment." Open Enrollment occurs every year regardless of the plan you have joined.

If you want to change your health plan, follow the steps in the letter you get from ICES. If you do not want to change, you do not need to do anything. You will continue to be a Member of Molina Healthcare.

If you wish to change your health plan, please review your options, especially if you wish to keep your doctors. Each plan has its own list of doctors and hospitals. You should see each plan's benefits and rules to help you make a decision.

To learn more about your options, call ICES at (877) 912-8880. To learn more about Molina Healthcare, call Member Services. If you have questions about your enrollment or disenrollment with Molina Healthcare please contact the Client Enrollment Service (CES) at (877) 912-8880.

Provider network:

Molina offers a large provider network to help you get the care and services you need. Molina's provider directory can help you find in-network providers. The provider directory lists the names, phone numbers and addresses of our in-network providers. The provider directory list includes primary care providers, specialists, urgent care centers, federally qualified health centers (FQHCs), community mental health centers (CMHCs), rural health clinics (RHCs), hospitals and other providers in your area. You may also use the directory to find a dentist, pharmacy or vision care provider.

Molina's provider directory is on our website. Visit MolinaHealthcare.com to find our in-network providers. If you need a printed copy of the provider directory, or need help with picking a provider, call Member Service at (855) 687-7861.

Primary Care Provider (PCP):

Your primary care provider is your personal doctor who will give you most of your care. Your doctor may send you to other providers if you need special care. With Molina Healthcare you can pick your PCP. You can have one PCP for your whole family or you can choose other PCPs for each family member.

- Your PCP will refer you to a specialist if you need one. A referral from your PCP is needed to see a specialist, except if the specialist is a women's health care provider (WHCP). Women may self-refer to a WHCP and have a WHCP in addition to their PCP. Women may change their WHCP at any time.
- Sometimes, a specialist may be your PCP. If you and your specialist believe that he or she should be your PCP, you or your specialist must call Member Services. Member Services will assist you in requesting the PCP change. If the change is approved, we will send you a new ID card with the specialist provider listed as your PCP.

If you are an American Indian/Alaskan Native member, you have the right to get services from an Indian Tribe, Tribal Organization or Urban Indian Organization provider in and outside of the State of Illinois.

If you need help in finding or changing your PCP, please contact Member Services at (855) 687-7861, Monday through Friday 8 a.m. to 5 p.m., or please visit MolinaHealthcare.com.

How to change PCPs:

You have the right to go to a PCP who meets your needs. You can change your PCP at any time. Please contact Member Services at (855) 687-7861. They can assist you Monday through Friday from 8 a.m. to 5 p.m. You can also change your PCP at MyMolina.com. Your PCP must be a network provider. Our in-network providers are listed online in our provider directory at MolinaHealthcare.com.

After you change your PCP, either online or through the Member Services Department, the change will be effective within 30 days. Molina Healthcare will send you a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP. If you would like help with picking a provider, call Member Services, Monday through Friday 8 a.m. to 5 p.m. at (855) 687-7861 (TTY/Illinois Relay: 711).

Women's Health Care Provider (WHCP):

As a woman with Molina Healthcare coverage, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor specializing in obstetrics, gynecology or family medicine.

Family planning:

Molina Healthcare has a network of family planning providers where you can get family planning services; however, you may choose to get family planning services and supplies from any out-of-network provider without a referral and it will be covered. You may self-refer to a women's health care provider. Family planning services include:

- Physical exam and counseling during a visit
- Diagnosis and treatment for sexually transmitted diseases
- Related laboratory and diagnostic testing (such as mammograms)
- Pregnancy testing and counseling, including infertility counseling
- Birth control medication
- Contraception devices, such as an intra-uterine device (IUD) and the implantable contraceptive
- Permanent methods of birth control, including tubal ligation, trans-cervical sterilization, and vasectomy
- Vaccinations, including Hepatitis B and HPV

Maternity (obstetric) care for pregnant women

It is very important that pregnant Members start care in the first 12 weeks of their pregnancy.

Molina Healthcare covers prenatal and postpartum care (typically six weeks after delivery). That includes hospital and delivery services. Postpartum depression screening is covered during the first year after you have your baby.

If you are pregnant or think you are pregnant, you may self-refer to any in-network Obstetrician (OB) or Obstetrician/Gynecologist (OB/GYN) provider. You may also call your primary care provider for a referral. It is important to stay with your provider throughout your pregnancy, especially during the last month.

Molina Healthcare has a special program for pregnant women. This program will help women get the education and services needed for a healthy pregnancy.

Depending on your needs, the following services may be provided:

- Counseling over the telephone.
- Educational workbooks and other resources.
- Coordination with social services.
- Care coordination services by a nurse.

If you are pregnant:

- See your provider when you first find out that you are having a baby.
- Do not miss any of your provider visits for prenatal care.
- See your provider right away if you have symptoms of a urine infection or other illness.
- The provider visits will help you to know how your baby is growing. They can help you get ready for your baby to be born.
- Your provider will be able to watch any problems that come up while your baby is growing. We want you to have a healthy pregnancy and a healthy baby.

As part of the program, you will also learn ways to stay healthy after your pregnancy.

Specialty care:

A specialist is a doctor who cares for you for a certain health condition. Examples of a specialist is cardiology (heart health), or orthopedics (bones and joints). If your PCP thinks you need a specialist, he or she will work with you to pick a specialist. Your PCP will arrange your specialty care. Your PCP will refer you to a specialist if you need one. A referral from your PCP is needed to see a specialist, except if the specialist is a women's health care provider (WHCP). Women may self-refer to a WHCP and have a WHCP in addition to their PCP. Women may change their WHCP at any time.

Sometimes, a specialist may be your PCP. If you and your specialist believe that he or she should be your PCP, you or your specialist must call Member Services at (855) 687-7861. Member Services will assist you in requesting the PCP change. If the change is approved, we will send you a new ID card with the specialist provider listed as your PCP.

Scheduling appointments:

It is very important that you keep appointments you make for doctor visits, lab test, or X-rays. Please call your PCP at least one day before your appointment day and time if you cannot keep an appointment. If you need help in making an appointment, please contact Member Services at (855) 687-7861, Monday through Friday, 8 a.m. to 5 p.m.

Urgent care:

Non-emergency care and after-hours

Non-emergency care and urgent care is when you need care right away, but you are not in danger of lasting harm or losing your life.

Some examples of urgent care are:

- Minor cuts and scrapes
- Colds
- Fever
- Ear ache
- Sore throat

Other examples are migraines, headaches, bladder infections, back pain and minor accidents and falls.

During normal business hours, call your PCP to ask questions about your care or make an appointment. Your PCP's phone number is on your ID Card.

If you need care after normal business hours, here are some steps you can take:

- Call your PCP. Even if the office is closed, your PCP will have a 24-hour answering service. Leave a message and someone will call you back. He or she will tell you what to do.
- Call Molina Healthcare's 24-Hour Nurse Advice Line. Our nurses will give you advice on what to do. They are always ready to help and answer your questions. They can confirm that you are eligible for benefits.
- Molina's 24-Hour Nurse Advice Line can help providers who are seeking prior approval for treatment when required.

Nurse Advice Line
English: (888) 275-8750
Spanish: (866) 648-3537
TTY for deaf and hard of hearing: 711

- If your PCP cannot see you right away or you have an urgent need, you can go to an urgent care center. Urgent care centers are listed in our provider directory. If you visit an urgent care center, call your PCP after your visit to schedule follow-up care.

Call your doctor for urgent care or you may call Molina Healthcare Member Services at (855) 687-7861.

Emergency care:

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness. An emergency is when you need care right away. Emergency care is for a medical problem that you think is so serious it must be treated right away. A prior authorization is not required for emergency care. We cover emergency care both in and out of the county where you live. Emergency care is available 24 hours a day, seven days a week. You do not need a referral to receive emergency care.

Our provider directory lists places that provide emergency care, including urgent care centers and hospitals. View our provider directory online at MolinaHealthcare.com.

Here are some examples of emergency-care situations:

- Heart attack
- Severe bleeding/severe burns
- Miscarriage or pregnancy with vaginal bleeding
- Seizures or convulsions
- Bleeding that does not stop
- Drug overdoses
- Poisoning
- Difficulty in breathing
- Broken bones

What to do in case of an emergency:

If you have an emergency, call 911 or go to the nearest emergency room (ER).

If you are not sure if you need to go to the ER, call your primary care provider or our 24-Hour Nurse Advice Line. Your PCP or our registered nurses will give you advice on what to do.

Nurse Advice Line
English: (855) 275-8750
Spanish: (866) 648-3537
TTY for deaf and hard of hearing: 711

If you call 911 or get emergency care, you must tell Molina Healthcare within 24 hours, or as soon as you can. This is so we can manage your care and give you the best care. You can have a family member or friend call for you.

After an emergency, call your PCP as soon as you can to let your PCP know about it. You may need to go to your PCP for follow-up care. Follow-up care is not an emergency. Call your PCP's office to set up an appointment if you need it. You may also call Member Services for help at (855) 687-7861, 8 a.m. to 5 p.m., Monday through Friday.

How to get emergency care

In an emergency, call 911. Call an ambulance if 911 services are not available.
Remember, if you need emergency care:

- Go to the nearest emergency room. Be sure to tell the person you see that you are a Member of Molina Healthcare. Bring your ID card. You must show them your ID card.
- If the provider treats you for the emergency, but thinks you need other care to treat the problem that caused your emergency, the provider must call Molina Healthcare.
- After an emergency room visit, call your PCP to make an appointment for follow-up care. Do not go to the emergency room for follow-up care.
- If the hospital admits you, call Member Services within 24 hours. A family member or friend can call us for you.

Post-stabilization care:

Post-Stabilization Services are services once you are stable after an emergency medical condition.

These services may help improve or resolve your condition. These services must be by an in-network provider or facility.

The provider must notify Molina Healthcare within one business day if you are to get these services. In-network places that provide post-stabilization services are listed in our provider directory. View the provider directory online at MolinaHealthcare.com. You can also call Member Services for help.

Covered services:

Molina Healthcare covers all medically necessary Medicaid-covered services. We cover the services at no cost to you. The Description of Coverage document helps you know which services are covered. Your Description of Coverage has a complete list of covered services. Visit our website at MolinaHealthcare.com for a copy. You may also call Member Services for a printed copy. Some limitations and prior authorization requirements may apply.

You must choose a PCP from Molina Healthcare's provider network. If you do not pick a PCP, one is assigned to you. You are the person who can best make the decision. Your PCP can be an individual physician or a physician group, an advanced practice nurse or advanced practice nurse group training in family medicine, a specialist or internal medicine practitioner. You have the right to change your PCP at MyMolina.com or by contacting Member Services.

Your PCP may refer you to a specialist. Sometimes your provider may need to us to approve a service before you receive the service (prior authorization). We will work with your provider to decide if you need the service. We call this process Utilization Management (UM). We make choices about your care based on medical need and your benefits. We do not reward providers or others to deny services you need. We do not pay extra money to providers or our UM staff to make choices that result in giving less care. Most services are available to you without prior authorization (PA).

If you have questions about a PA request, call Member Services at (855) 687-7861. Molina staff is here to help 8 a.m. to 5 p.m., Monday to Friday. After business hours, you can leave a message. Your call will be returned the next business day.

Covered medical services:

Here is a list of some of the medical services and benefits that Molina Healthcare covers.

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Abortion	Abortion services are covered by Medicaid (not your MCO) by using your HFS Medical card.	Not Applicable
Advanced Practice Nurse Services	Covered benefit	PA is not required.
Ambulatory Surgical Treatment Center Services	Covered benefit Some limitations apply	Some ambulatory surgeries require PA.
Assistive/Augmentative Communication Devices	Covered benefit	Some services require PA. Some services are not covered.
Blood, blood components and the administration thereof	Covered benefit	PA is not required.
Chiropractic services for enrollees under the age of twenty-one (21)	Covered benefit. Limited to Members 20 years of age and younger for the treatment of spine by manual manipulation.	PA is required.
Dental services including oral surgeons (20 years of age or younger)	Covered benefit. Dental services, including oral surgery, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling) Cleanings (one every six months) Dental exams (one every six months) Some limits apply	PA is required.

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Dental services (21 years of age and older)	Covered benefit. Dental services including oral surgery, X-rays, fillings, crowns (caps), root canals, extractions (pulling), dentures and denture repairs. Pregnant women can get extra services. The services include exams, cleanings and deep cleanings. As an additional benefit, Members 21 years of age and older get: Cleanings (one every six months) Dental exams (one every six months) Some limitations apply	PA is required.
Emergency dental services	Covered benefit	PA is not required.
Diagnostic services	Covered benefit	Diagnostic services CT scans, MRIs, MRAs, PET Scans, and SPECT require PA. PA is not required for lab service. Genetic testing requires PA.
Durable Medical Equipment (DME)	Covered benefit. Some limitations apply.	Some durable medical equipment items require PA.
Emergency services	Covered benefit	PA is not required.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for Enrollees under the age of twenty-one (21)	Covered for Members 20 years of age or younger. Excludes shift nurses serving for Members in the Medically Fragile and Technology Dependent (MFTD waiver or Long Term Services and Supports waivers.	PA is not required.

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Family Planning Services and supplies	Covered benefits include: Yearly exam for females 12 to 55 years of age, which includes a breast exam, pelvic exam and pap smear. Pregnancy testing. Contraceptive-related services such as the insertion of intrauterine devices (IUDs) and the implantable contraceptive; permanent methods of birth control, including tubal ligation, trans-cervical sterilization and vasectomy. Contraceptive supplies, such as birth control pills, rings, patches and emergency contraception.	PA is not required.
Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and other Encounter rate clinic visits	Covered benefit	PA is not required.
Hearing (audiology) services, including hearing aid	Covered benefit	PA is not required.
Home Health Services	Covered benefit Also includes nursing care for Members 20 years of age and younger who are not in the Medically Fragile and Technology Dependent (MFTD) waiver.	Requires PA.
Hospice care (care for terminally ill)	Covered benefit	PA is not required.
Immunizations (shots)	Covered benefit	PA is not required.

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Inpatient hospital	Covered benefit	Inpatient hospital services (except for emergency admissions) and elective admissions require PA. Notification to Molina Healthcare is required within 24 hours of admission or by the next business day for emergency admissions.
Long Term Services and Supports	Determination of need must be completed for individuals eligible for waivers	Requires PA.
Laboratory and X-ray services	Covered benefit	Some services may require PA.
Medical supplies, equipment, prostheses and orthoses	Covered benefit Some limitations apply	Some medical supplies require PA.
Mental health and substance abuse services	Covered benefit	Authorization is not required for outpatient services received at an in-network • Community Mental Health Center • Division of Mental Health (DMH) facility • Division of Alcoholism and Substance Abuse (DASA) facility • Illinois Department of Human Services (DHS) Facility PA is required for the following Mental Health, Alcohol and Chemical dependency services: • Inpatient and Residential Treatment, • Electroconvulsive Therapy (ECT)
Nursing facility services	Covered benefit	Short-term inpatient rehabilitative nursing facility requires PA

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Obstetrical (maternity care) and gynecological services	Covered benefit Practice visits for individuals with developmental disabilities and serious illness. Includes office visits for prenatal, postpartum and newborn care, which included breast pumps, hospital and delivery services Includes at-risk pregnancy services Women may self-refer to Obstetrician (OB) or Obstetrician/Gynecologist (OB/GYN) provider	PA is not required
Outpatient hospital services	Covered benefit Some limitations apply	Some outpatient services require PA.
Optical services and supplies	Covered benefit	Services and supplies authorized by dental provider.
Optometrist services	Covered benefit	Services authorized by dental provider.
Pharmacy services	Covered benefit	Some services require PA.
Physical and occupational services	Covered benefit	PA is required.
Podiatry (foot) services	Covered benefit	PA is not required
Post-stabilization services	Covered benefit	Notification from provider to Molina Healthcare is required.
Prescription drugs, including certain prescribed over-the-counter drugs	Covered benefit	Select drugs, including injectable drugs and some over-the-counter drugs, require PA.
Preventive mammogram (breast) and cervical cancer (pap smear) exams	Covered benefit Women may self-refer	PA is not required
Preventive male cancer screenings	Covered benefit	PA is not required
Primary Care Provider (PCP) services	Covered benefit	PA is not required
Renal dialysis (kidney disease) services	Covered benefit	Notification is not required

Service	Coverage and Benefit Limitations	Prior Authorization (PA)
Respiratory Equipment and supplies	Covered benefit Some limitations apply	Some services require PA
Specialist services	Covered benefit	Office visits to see an in-network specialist do not require PA.
Speech therapy services	Covered benefit	Requires PA after initial evaluation and (6) six visits in outpatient and/or home setting.
Transplants	Covered benefit Limited to transplant providers certified by state of Illinois	PA is required.
Transportation to covered services, pharmacy trips and the Women, Infants and Children (WIC) office appointments (Non-Urgent)	Covered benefit	PA is not required for trips to covered services. Air or ground ambulance transportation for non-emergencies requires PA.
Vision (optical and optometrist) services, including eyeglasses	One exam per year for all Members One pair of eyeglasses (lenses and frames) in a two-year period for all Members No restrictions on replacement eyeglasses for Members 0 to 20 years of age Members 21 years of age and older are limited to replacement lenses when medically necessary As an additional benefit, Molina Healthcare provides a $40 credit to use toward your eyeglasses benefit (lenses and frames) per year	PA is not required.
Well child exams (EPSDT Services)	Covered benefit	PA is not required.
Yearly well-adult exams	Covered benefit	PA is not required.

Covered home and community based services (Waiver clients only):

Here is a list of some of the medical services and benefits that Molina Healthcare covers for Members who are in a Home and Community Based service waiver.

Department on Aging (DoA), *for persons who are elderly:*

- Adult Day service;
- Adult Day service Transportation;
- Homemaker;
- Personal Emergency Response System (PERS);

Department of Rehabilitative Services (DRS), *for persons with disabilities or persons with HIV/AIDS*

- Adult Day service;
- Adult Day service Transportation
- Environmental Accessibility Adaptations-Home;
- Home Health Aide;
- Nursing Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;
- Home Health Aide;
- Physical Therapy;
- Speech Therapy;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);
- Respite;
- Specialized Medical Equipment and Supplies;

Department of Rehabilitative Services (DRS), *for persons with a brain injury*

- Adult Day service;
- Adult Day service Transportation;
- Environmental accessibility Adaptations-Home;
- Supported Employment;
- Home Health Aide;
- Nursing, Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;

- Physical Therapy;
- Speech Therapy;
- Prevocational Services;
- Habilitation-Day;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);
- Respite;
- Specialized Medical Equipment and Supplies;
- Behavioral Services (M.A. and PH.D.)

HealthCare and Family Services (HFS), *Supportive Living Facility:*

- Assisted Living

Managed Long Term Support & Services (MLTSS) covered services:

MLTSS covered services include:

- Mental health services like: Group and Individual Therapy, Counseling, Community Treatment, Medication Monitoring and more
- Alcohol and substance use services like: Group and Individual therapy, Counseling, Rehabilitation, Methadone services, Medication Monitoring and more
- Some transportation services to appointments
- Long Term Care services in skilled and intermediate facilities
- All Home and Community Based Waiver Services like the ones listed above under 'Covered HCBS Services' if you qualify

Limited covered services:

- Health plan may provider sterilization services only as allowed by State and federal law.
- If Health plan provides a hysterectomy, Health plan shall complete HFS Form 1977 and file the completed form in the Enrollee's medical record.

Non-covered services:

Here is a list of some of the medical services and benefits that Molina Healthcare does not cover:

- Services that are experimental or investigational in nature;
- Services that are provided by a non-Network Provider and not authorized by your Health Plan
- Services that are provided without a required referral or required prior authorization;
- Elective cosmetic surgery

- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies
- Early Intervention Services, including Care Management
- Services funded through the Juvenile Rehabilitation Services Matching Fund
- Services such as assisted suicide

For additional information on services, please contact Member Services at (855) 687-7861, Monday through Friday, 8 a.m. to 5 p.m., or visit MolinaHealthcare.com.

Dental services:

Taking care of your teeth and gums keeps you healthy. You should visit your dentist regularly. Cleanings can help prevent cavities and other problems with your teeth. See our provider directory to find a Molina Healthcare in-network dentist. Access the provider directory by visiting MolinaHealthcare.com.

Your dental home

As a Molina Healthcare of Illinois & DentaQuest member, you have a Dental Home. Your Dental Home is where you go to get dental care. This dentist will provide any needed oral health care for you.

Your Dental Home will work with you so you can stay healthy. It is important to go back to the same Dental Home for each appointment.

Your Dental Home will provide:

- Complete dental care
- A dental health plan designed for you
- Guidance about diet and growth
- Information on how to care for your teeth

Healthy teeth and gums are an important part of overall health. It is recommended that you have checkups -every six months. Children should see the dentist starting at age one.

Don't wait! Call your Dental Home and make an appointment today.
If you have questions about your Dental Home or dental benefits or would like to change your Dental Home, call toll free 844.583.5037 or visit our website at DentaQuest.com.
Please remember: It is important to keep all your appointments and arrive on time.

Vision services:

To help keep your eyes healthy, Molina Healthcare covers one eye exam per year for Members. For Adults age 21 and older we cover one pair of eyeglasses (frames and lenses) every two years. Adults may receive an additional pair of eyeglasses within a two-year period, if they've had a surgical procedure such as cataract surgery that necessitates a new pair Members 0-20 years of age have no restrictions on replacement eyeglasses.

As an additional benefit, Molina Healthcare provides a $40 credit to use toward your eyeglasses benefit (lenses and frames) per year, for Members who choose outside of the approved options.

Refer to our provider directory to find an eye doctor contracted with Molina Healthcare. Access our provider directory at MolinaHealthcare.com.

If you have questions about your vision benefits, please call Member Services at (855) 687-7861.

Pharmacy services:

As a Molina Healthcare Member, you get prescription drug coverage at no cost to you. We cover your prescriptions when you get your drugs filled at an in-network pharmacy. We cover all medically necessary prescription drugs. We use a Preferred Drug List (PDL). These are drugs that we prefer that your provider prescribe. For a copy of our PDL, visit our website at MolinaHealthcare.com. You may also call Member Services.

To have a prescription filled, simply take your prescription and your Molina Healthcare ID card to an in-network pharmacy. If your prescribed medication is listed on the PDL or if you have a prior authorization for the medication, you will receive your medication free of charge.

Molina Healthcare also covers over-the-counter drugs on our PDL at no cost to you. You will need a prescription from your provider to get the over-the-counter drug covered.

To be sure you have the care you need, we may ask your provider to submit a request. Your provider will need to explain why you need a certain drug or certain amount of a drug. We must approve the request before you can get the medication. This is called prior authorization. Reasons why we may require prior authorization of a drug include:

- The drug is not on the Preferred Drug List
- The drug is being used for a health condition that the Food and Drug Administration (FDA) did not approve
- The prescription is being refilled too soon after it was first filled
- There are other drugs that must be tried first
- There is a generic or other alternative drug available
- The drug can be misused or abused

If we do not approve a PA request for a drug, we will send you a letter. The letter will explain how to appeal our decision. It will explain your rights to a state hearing.

Some drugs may have a quantity amount limit and some other drugs are not covered, even with a prior authorization. Some of the drugs that are not covered include:

- Drugs for weight loss
- Drugs for cosmetic purposes
- Drugs to treat infertility
- Drugs to treat erectile dysfunction
- Experimental or Investigational drugs
- The drug is being used for a health condition that the Food and Drug Administration (FDA) did not approve

We require the use of generic drugs when available. If your provider thinks you need a brand name drug, the provider may submit a PA request. Molina Healthcare will determine whether to approve the brand name drug. Remember to fill your prescriptions before you travel out of state.

Our PDL can change. Remember to check the PDL when you need to fill or refill a medication.

Refer to our provider directory to find an in-network pharmacy. Our provider directory is online at MolinaHealthcare.com. You can also call Member Services to find an in-network pharmacy near you. Molina Healthcare will only pay for drugs you get from an in-network pharmacy.

Transportation services:

To help you get the care you need, Molina Healthcare can provide you a ride if you need it. We cover transportation if you need. We offer rides to and from your provider appointments and WIC offices. This includes appointments for medical equipment. We also cover trips to the pharmacy to pick up a prescription.

Medical appointments include trips to:

- A PCP or provider visit
- A clinic
- A hospital
- A therapy or behavioral health appointment

To schedule a ride, or if you have questions, call (844) 644-6354 (TTY: 711). Call as soon as possible to schedule your ride, but no later than 72 hours before your appointment. If you need to plan a pharmacy stop prior to you leaving your providers office or have questions, you may also call (844) 644-6354 (TTY: 711). Ask your doctor to call your prescription in to the pharmacy so it's ready when you get there. Let your driver know you need to stop at the pharmacy.

Plan ahead!
Molina Healthcare may not be able to schedule your transportation if you do not call at least 72 hours in advance of your appointment.

Added benefits:

Type of Extra Benefit	
Vision Services	Members may get a yearly $40 credit to use toward eyeglasses (lenses and frames) if choosing outside of the approved options.
Dental Services	Dental services are available for adults 21 and older. Molina allows two visits for oral exam and two cleanings per year, in addition to bitewing X-ray once a year.
Transportation	We cover transportation to the pharmacy, a DME provider, the pharmacy and to Women, Infants and Children appointments.
Smoking Cessation	This program includes an assessment call regarding: readiness to quit, motivation for quitting; identifying triggers; establishing a quit date, and taking steps to reach your goal.

Weight management	This program includes an initial call to determine your motivation for weight loss, readiness to start a weight management routine, tips for health eating, how to read food labels.
Molina Cares	This program offers gift cards to Members for completing select preventive services.
Motherhood Matters	Molina offers a pregnancy program called Motherhood Matters to help keep its Members and their family's health. This program includes counseling over the phone, educational workbooks, coordination with social services and case management services by a nurse.

Cost sharing:

This plan contains no cost sharing obligations.

Care coordination:

Living with health problems can be hard. Molina Healthcare's care coordination program can help you get the care and medical services you need. The care coordination program can help you to:

- Make and update care plans to meet your health care needs
- Set up appointments, tests or transportation
- Identify any gaps in your care
- Coordinate your care with your providers
- Understand the benefits and services you get as a Molina Healthcare Member
- Connect you to additional assistance and community resources

Molina Healthcare has case managers to help you. Case managers are medical or behavioral health professionals. They can help you if you have a medical condition or multiple medical conditions that requires extra attention, such as:

Asthma, behavioral and mental health disorders, cancer, chemical dependency, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD), diabetes, high blood pressure, high-risk pregnancy, kidney disease, sickle cell anemia, terminal illness.

To learn more about Molina Healthcare's care coordination program, call Member Services at (855) 687-7861.

Disease/Health education management programs:

Health management programs

If you are living with a chronic health illness or behavioral health illness, Molina Healthcare has Health Management Programs that can help. The programs are free. They provide learning tools, advice and care tips. We enroll you into a program(s) if you have certain health conditions. As part of these programs, a case manager will contact you. The case manager will work with you and your doctor.

Your provider may also refer you to a program. To self-refer to a program, call us. It is your choice to be in a program. You can ask to be removed from a program any time.

Call our Health Management Department at (866) 891-2320 (TTY: 711) to learn more about the programs.

HIV data sharing

Molina Healthcare is working with the State of Illinois to stop new HIV cases. The Illinois Department of Public Health is sharing HIV data they have with IL Medicaid and IL Medicaid Manager Care Organizations to have better care for people living with HIV. Name, date of birth, SSN, HIV status and other information is being shared safely and securely for all Medicaid members.

Weight management program

Our weight control program is designed to help adults and children manage their weight. As part of the program, you and your family will learn about healthy eating and exercise.

To learn more or to enroll, call our Health Management Department at (866) 472-9483 (TTY: 711).

Smoking cessation program

If you are ready to quit smoking, we have a program to help you. Our Free and Clear® smoking cessation program is available at no cost to you. With the program, you will get:

- Free one-on-one counseling
- Free educational materials and information
- A toll-free quit line to call anytime for help
- Appropriate stop-smoking aids, such as nicotine replacement therapy, based on what you and your provider decide is right for you

Quitting smoking has many benefits. It lowers your risk for diseases and death caused by smoking. And it improves your health. Call our Health Management Department at (866) 472-9483 to learn more and enroll.

Recipient restriction program:

Pharmacy coordination program

Molina Healthcare cares about your health. We want Members to get quality services and safe medical care. The Pharmacy Coordination Program helps Members who visit many providers and pharmacies for prescription opioid drugs and may have a substance use disorder.

As part of the program, you will pick one pharmacy for all your medications. And one provider will help with your pain related care. And a case manager will to work with you. To learn more, call Member Services.

Advance directives:

You have the right to make decisions about the health care you get now and in the future. You can make decisions now about the care you want to get if you become too ill to speak for yourself. An advance directive is a written decision you make about your health care in the future

in case you are so sick you can't make a decision at that time. In Illinois there are four types of advance directives:

- **Healthcare Power of Attorney** - This lets you pick someone to make your health care decisions if you are too sick to decide for yourself.
- **Living Will** - This tells your doctor and other providers what type of care you want if you are terminally ill and you will not get better.
- **Mental health Preference** - This lets you decide if you want to receive some types of mental health treatments that might be able to help you.
- **Do Not Resuscitate (DNR) order**- This tells your family and all your doctors and other providers what you want to do in case your heart or breathing stops.

You can get more information on advance directives from your health plan or your doctor. If you are admitted to the hospital they might ask you if you have one. You do not have to have one. You do not have to have one to get your medical care but most hospitals encourage you to have one. You can choose to have any one or more of these advance directives if you want and you can cancel or change it at any time.

- Anyone 18 years of age or older who is of sound mind and can make his or her own decisions can have an advance directive. You do not need a lawyer to fill out an advance directive. Still, you make decide you want to talk with a lawyer. Talk to your provider to get an advance directive form. You can also call Member Services for an advance directive form.
- Once you have received and filled out your advance directive forms and properly signed them, keep them in a safe place and provide copies to your PCP and family members.
- The form will tell your family, providers and those who need to know how you want to be cared for during an illness or medical emergency. The form will tell how you want to be cared for even when you can no longer speak for yourself. After you complete the form, it will be put in your medical file. You can end or change the advance directive at any time. You just need to talk to your provider. If you have any questions, Member Services is here to help you.

Grievance & appeals:

We want you to be happy with services you get from Molina Healthcare and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item. Molina Healthcare takes Member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. Molina Healthcare has special procedures in place to help Members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

If the grievant is a customer of the Vocational Rehabilitation (VR) program, the grievant may have the right to the assistance of the DHS-ORS Client Assistance Program (CAP) in the preparation, presentation and representation of the matters to be heard.

These are examples of when you might want to file a grievance.

- Your provider or a Molina Healthcare staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a Molina Healthcare staff member was rude to you.
- Your provider or a Molina Healthcare staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Molina Healthcare at (855) 687-7861 (TTY/Illinois Relay Service: 711). You can also file your grievance in writing via mail or fax at:

Molina Healthcare of Illinois
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Member ID number. You can ask us to help you file your grievance by calling Member Services at (855) 687-7861.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing impaired, call the Illinois Relay at 711.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Molina Healthcare in writing the name of your representative and his or her contact information.

We will work to resolve your grievance right away. If we cannot, we may contact you for more information.

Appeals

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Adverse Benefit Determination" letter from us. The letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services

You may not agree with a decision or an action made by Molina Healthcare about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Adverse Benefit Determination form. If you want your services to stay the same while you appeal, you must say so when you appeal

and you must file your appeal no later than **ten (10) calendar days** from the date on our Adverse Benefit Determination form. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

Here are two ways to file an appeal.

1) Call Member Services at (855) 687-7861. If you file an appeal over the phone, you must follow it with a written signed appeal request.
2) Mail or fax your written appeal request to:

Molina Healthcare of Illinois
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515
Fax: (855) 502-5128

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your appeal. If you have a hearing impairment, call the Illinois Relay at 711.

Can someone help you with the appeal process?

You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at MolinaHealthcare.com.

Appeal process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

Molina Healthcare will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Molina Healthcare may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Decision Notice. The Decision Notice will tell you what we will do and why.

If Molina Healthcare's decision agrees with the Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If Molina Healthcare's decision does not agree with the Adverse Benefit Determination, we will approve the services to start right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Molina Healthcare reviews your appeal.

How can you expedite your appeal?

If you or your provider believes our standard timeframe of fifteen (15) business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, Member ID number, the date of your Adverse Benefit Determination letter, information about your case and why you are asking for the expedited appeal. We will let you know within twenty-four (24) hours if we need more information. Once all information is provided, we will call you within twenty-four (24) hours to inform you of our decision and will also send you and your authorized representative the Decision Notice.

How can you withdraw an appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Molina Healthcare will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Molina Healthcare at (855) 687-7861.

What happens next?

After you receive the Molina Healthcare appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within **thirty (30) calendar days** of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State fair hearing

If you choose, you may ask for a State Fair Hearing Appeal within **one hundred and twenty (120) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Molina Healthcare Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

You can ask for a State Fair Hearing in one of the following ways:

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- Visit Abe.Illinois.gov/Abe/Access/Appeals to set up an ABE Appeals Account and submit a State Fair Health Appeal online. This will allow you to track and manage your appeal online, viewing important dates and notices related to the State Fair Hearing and submitting documentation.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-2005
Email: HFS.FairHearings@illinois.gov

Or you may call (855) 418-4421, TTY: (800) 526-5812

- If you want to file a State Fair Hearing Appeal related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service, send your request in writing to:

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-8573
Email: DHS.HSPAppeals@illinois.gov

Or you may call (800) 435-0774, TTY: (877) 734-7429

State fair hearing process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at Abe.illinois.gov/Abe/Access/Appeals you can access all letters related to your State Fair Hearing process through your ABE Appeals Account. You can also upload documents and view appointments.

At least three (3) business days before the hearing, you will receive information from Molina Healthcare. This will include all evidence we will present at the hearing. This will also be sent to

the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to Molina Healthcare and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

You will need to notify the appropriate Hearings Office of any accommodation you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

Continuance or postponement

You may request a continuance during the hearing, or a postponement prior to the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, you and all parties to the appeal will be notified in writing of a new date, time and place. The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

Failure to appear at the hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within ten (10) calendar days from the date you received the Dismissal Notice, if the reason for your failure to appear was:

- A death in the family
- Personal injury or illness which reasonably would prohibit your appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or your authorized representative a letter rescheduling the hearing with copies to all parties to the appeal.

If we deny your request to reset your hearing, you will receive a letter in the mail informing you of our denial.

The state fair hearing decision

A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. The Decision will also be available online through your ABE Appeals Account. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

External review (for medical services only)

Within thirty (30) calendar days after the date on the Molina Healthcare appeal Decision Notice, you may choose to ask for a review by someone outside of Molina Healthcare. This is called an external review. The outside reviewer must meet the following requirements:

- Board certified provider with the same or like specialty as your treating provider

- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your identity during the review

External Review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

Your letter must ask for an external review of that action and should be sent to:

Molina Healthcare of Illinois
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

What happens next?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Molina Healthcare a letter with their decision within five (5) calendar days of receiving all the information they need to complete their review.

Expedited external review

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an **expedited external review.** You can do this on the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at (855) 687-7861. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Molina Healthcare of Illinois
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your

request. They will let you and/or your representative and Molina Healthcare know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Molina Healthcare with the decision within forty-eight (48) hours.

Rights & responsibilities:

Your rights:

- Be treated with respect and dignity at all times.
- Have your personal health information and medical records kept private except where allowed by law.
- Be protected from discrimination.
- Receive information from Molina Healthcare in other languages or formats such as with an interpreter or Braille.
- Receive information on available treatment options and alternatives
- Receive information necessary to be involved in making decisions about your healthcare treatment and choices.
- Refuse treatment and be told what may happen to your health if you do.
- Receive a copy of your medical records and in some cases request that they be amended or corrected.
- Choose your own primary care provider (PCP) from Molina Healthcare. You can change your PCP at any time.
- File a complaint (sometimes called a grievance), or appeal without fear of mistreatment or backlash of any kind.
- Request and receive in a reasonable amount of time, information about your Health Plan, its providers and polices.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

Your responsibilities:

- Treat your doctor and the office staff with courtesy and respect.
- Carry your Molina Healthcare ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.
- Keep your appointments and be on time for them.
- If you cannot keep your appointments cancel them in advance.
- Follow the instructions and treatment plan you get from your doctor.
- Tell your health plan and your caseworker if your address or phone number changes.
- Read your Member handbook so you know what services are covered and if there are any special rules.

Fraud, waste and abuse:

If you suspect cases of fraud, waste, or abuse you must report it by contacting the Molina Healthcare AlertLine.

AlertLine is an external telephone and web based reporting system hosted by NAVEX Global, a leading provider of compliance and ethics hotline services. AlertLine telephone and web based reporting is available 24 hours a day, 7 days a week, 365 days a year.

When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Molina Healthcare

Compliance Department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report.

Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Molina Healthcare AlertLine can be reached toll free at (866) 606-3889 (TTY: 711) or you may use the service's website to make a report at any time at **MolinaHealthcare.AlertLine.com.**

You may also report cases of fraud, waste or abuse to Molina Healthcare of Illinois Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare of Illinois
Attn: Compliance
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

How to report abuse, neglect, exploitation and other critical incidents:

Fraud, Waste and Abuse, in addition to Neglect, Exploitation and Unexplained Death are all incidents that need to be reported. Fraud occurs when someone receives benefits or payments they are not entitled to.

Some other examples of fraud are:

- To use someone else's ID card or let them use yours.
- A provider billing for services that you did not receive.

Abuse is when someone causes physical or mental harm or injury. Here are some examples of abuse:

- Physical abuse is when you are harmed such as slapped, punched, pushed or threatened with a weapon.
- Mental abuse is when someone uses threatening words at you, tries to control your social activity, or keep you isolated.
- Financial abuse is when someone uses your money, personal checks or credit cards without your permission.
- Sexual abuse is when someone is touching you inappropriately and without your permission.

Neglect occurs when someone decides to hold the basic necessities of life such as food, clothing, shelter or medical care.

Unexplained Death means a death with unknown causes. This includes a death not caused by a previously identified diagnosis, or a death that occurred during or after an unusual incident, or is suspected to have occurred as a result of abuse or neglect.

If you believe you are a victim you should report this right away. You can call Member Services at (855) 687-7861. You may also call one of the following agencies. All reports are confidential and can be anonymous.

Nursing home hotline – (800) 252-4343

Illinois Department of Public Health Nursing Home Hotline is for reporting complaints regarding hospitals, nursing facilities, and home health agencies and the care or lack of care of the patients.

Office of the inspector general – (800) 368-1463

The Illinois Department of Human Services Office of Inspector General Hotline is to report allegations of abuse, neglect, or exploitation for people 18 to 59 years old.

Adult protective services hotline – (866) 800-1409

To report abuse, neglect, or exploitation of individuals 18 to 59 years of age with a disability or people 60 years of age and older, call Adult Protective Services Hotline.

Illinois child abuse hotline - (800) 252-2873.

The Illinois Child Abuse Hotline is for reporting of abuse neglect or exploitation of member's under the age of 18

Supportive Living Facility (SLF) complaint hotline – (800) 226-0768

The Illinois Department of Healthcare and Family Services' Hotline is to report abuse, neglect, or exploitation for people living in Supportive Living Facilities (SLF).

Suspected fraud and abuse may also be reported directly to the state of Illinois at:

Illinois State Police
Medicaid Fraud Control Unit
8151 W. 183rd Street, Suite F
Tinley Park, Illinois 60477

Member privacy

Your privacy is important to us. We respect and protect your privacy. Molina uses and shares your information to provide you with health benefits. Molina wants to let you know how your information is used or shared.

Why does Molina use or share your Protected Health Information (PHI)?

- To provide for your treatment
- To pay for your health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To share PHI as required or permitted by law

The above is only a summary. Our Notice of Privacy Practices gives more information about how we use and share our Members' PHI. You may find our full Notice of Privacy Practices on our website at MolinaHealthcare.com.

Definitions:

Appeal means a request for your health plan to review a decision again.

Co-payment means a fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment means equipment and supplies ordered by a health care provider for everyday or extended use.

Emergency Medical Condition means an illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Services means the evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services means health care services that your health insurance or plan doesn't pay for or cover.

Grievance means a complaint that you communicate to your health plan.

Habilitation Services and Devices means services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Health Care means health care services a person receives at home.

Hospice Services means services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization means care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care means care in a hospital that usually doesn't require an overnight stay.

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

Out of Network means providing a beneficiary with the option to access plan services outside of the plan's contracted network of providers. In some cases, a beneficiary's out-of-pocket costs may be higher for an out-of-network benefit.

Prior Authorization means a decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. It is sometimes called pre-authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Prescription Drug Coverage means health insurance or plan that helps pay for prescription drugs and medications.

Primary Care Provider means a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Rehabilitation Services and Devices means health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care means nursing services provided within the scope of the Illinois Nurse Practice Act
(225 ILCS 65/50-1 et seq.) by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the State.

Specialist means a physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care means 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.

Molina Healthcare of Illinois

Authorized representative designation

To have someone else act on your behalf on an appeal or grievance, complete and return this form. The person listed will be accepted as your authorized representative. We are unable to speak with anyone on your behalf unless this form is completed, signed, and returned to us.

Molina Healthcare
Attention: Appeals & Grievance Coordinator
2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515
Fax: (855) 502-5128

Member Information

Member Name:_____ Date of Birth: _____

Member ID Number (on your Molina Healthcare ID card): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Authorized Representative Information

I (the Member) hereby authorize the following person to act on my behalf in the filing and processing of my appeal with Molina Healthcare:

Name of Authorized Representative: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Alternative Phone Number: _____

Relationship: ☐ Parent ☐ Guardian ☐ Conservator Other: _____

Briefly describe the service and date(s) (if applicable) for which the Authorized Representative will be acting on your behalf:

Member Signature

Print Member Name:	Date:
Signature of Member:	Date:

Authorized Representative Signature

Print Name of Authorized Representative:	Date:
Signature of Authorized Representative:	Date:

Please note you may revoke this authorization at any time. If you have any questions, please call Molina Healthcare Member Services at **(855) 687-7861** or TTY: 711.

Authorization for the use and disclosure of protected health information

Name of Member: _____ Member ID#: _____

Member Address: _____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information as described below.

1. Name of persons/organizations authorized to make the requested use or disclosure of protected health information:

Molina Healthcare

2. Name of persons/organizations authorized to receive the protected health information:

3. Specific description of protected health information that may be used/disclosed:

4. The protected health information will be used/disclosed for the following purpose(s):

5. The person/organization authorized to use/disclose the protected health information will receive compensation for doing so. Yes____ No_X_

6. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment, payment for or coverage of services, or ability to obtain treatment, except as provided under numbers 7 and 8 on this form.

7. Molina Healthcare may condition the provision of research related treatment on my provision of an authorization for the use or disclosure of PHI for such research.

8. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, Molina Healthcare reserves the right to deny that health care.

9. I understand that I have a right to receive a copy of this authorization, if requested by me.

10. I understand that I may revoke this authorization at any time by notifying Molina Healthcare in writing, except to the extent that:
    a) action has been taken in reliance on this authorization; or
    b) if this authorization is obtained as a condition of obtaining health care coverage, other law provides the health plan with the right to contest a claim under the benefits or coverage under the plan.

11. I understand that the information I authorize a person or entity to receive may be no longer protected by federal law and regulations.

12. This authorization expires on the following date or event* _____

**If no expiration date or event is specified above, this authorization will expire 12 months from the date signed below.*

Signature of Member or Member's Personal Representative	Date
Printed Name of Member or Member's Personal Representative	Relationship to Member or Representative's Authority to act for the Member, if applicable

A copy of this signed form will be provided to the member, if the authorization was sought by Molina Healthcare

Molina Healthcare of Illinois (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Molina does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Molina provides free aids and services to people with disabilities to communicate effectively with us, such as.

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - o Qualified interpreters
    - o Information written in other languages

If you need services, contact the Civil Rights Coordinator. If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
200 Oceangate
Long Beach, CA 90802
Email: Civil.Rights@MolinaHealthcare.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at Ocrportal.hhs.gov/Ocr/Portal/Lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)
Complaint forms are available at Hhs.gov/Ocr/Office/File/Index.html.

MHI FHP Medicaid – Statement 1557_v2
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English	ATTENTION: If you speak English, language assistance services,free of charge, are available to you. Call 1-855-687-7861 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.Llame al 1-855-687-7861 (TTY: 711).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-687-7861 (TTY: 711).
Chinese	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 1-855-687-7861（TTY：711）。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-687-7861 (TTY: 711) 번으로 전화해 주십시오.
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-687-7861 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-687-7861 (رقم هاتف الصم والبكم:711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-687-7861 (телетайп: 711).
Gujarati	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષ સહાય સેવાઓ તમારા માટે ઉપલબ્ છે. ફોન કરો 1-855-687-7861 (TTY: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1855-687-7861 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-687-7861 (TTY: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-687-7861 (TTY: 711).
Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-687-7891 (TTY: 711) पर कॉल करें।
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-687-7861 (TTY : 711).
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-687-7861 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-687-7861 (TTY: 711).

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