Welcome to the Molina family.

Member Handbook

Molina Healthcare of Illinois
Integrated Care Program

Issued October 2013

MOLINA® HEALTHCARE

Your Extended Family.

Important Molina Healthcare Phone Numbers

Member Services
(855) 766-5462
TTY/Illinois Relay Service: 711

24-Hour Nurse Advice Line
English: (888) 275-8750
Español: (866) 648-3537
TTY: (866) 735-2929

24-Hour Behavioral Health Crisis Line
English: (888) 275-8750
Español: (866) 648-3537
TTY: (866) 735-2929

Transportation
(877) 917-8164
TTY/Illinois Relay Service: 711

Care Coordination
(855) 766-5462
TTY/Illinois Relay Service: 711

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Welcome to Molina Healthcare!

You are now a member of Molina Healthcare of Illinois. Molina Healthcare is a health care plan, also known as a Managed Care Organization (MCO), that provides services to Seniors and Persons with Disabilities (SPD) Medicaid consumers.

This handbook is your guide to your benefits. Please read it carefully. It explains:

- The process for getting health care services
- Important information on the extra benefits that are available to you as a member
- Contact information so that you know whom to call

Language Help

This member handbook is also printed in Spanish. The English and Spanish versions are on our website at www.MolinaHealthcare.com. You may call Member Services to request a printed copy of this handbook in Spanish at no cost to you. For hearing impaired members, call the Illinois Relay Service at 711 for help at no cost to you.

If you have any problems in reading or understanding this or any other Molina Healthcare information, please call Member Services at (855) 766-5462 for help. We can explain the information orally, in English or in your primary language, or print it in your primary language or in certain ways. These services are free.

Interpretive Services

Molina Healthcare offers interpretive services, translation or language help to those who need them. These services are free. If your doctor does not speak your language or does not have someone who can talk to you in you a way that you can understand, please contact Molina Healthcare for help.

Member Services Department

If you have any questions, call Molina Healthcare Member Services. For example, Member Services representatives can help you:

- Understand your benefits
- Update your contact information
- Request a new ID card
- Schedule transportation
- Pick a primary care provider (PCP)

You can contact Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711) from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Visit our website at www.MolinaHealthcare.com for current information. Also on our website you can:

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

This handbook is also posted at www.MolinaHealthcare.com. You may request printed copies of information on our website by calling Member Services.

The following icons point out important information in this handbook. They will help you to know how to get the most out of being a Molina Healthcare member.

Important Information

This icon points out tips and reminders that will help you use your benefits.

Only a Click Away

We post current and up-to-date information on our website at www.MolinaHealthcare.com. You can also visit MyMolina.com for 24-hour access to many online self-services.

Medical Home

One of the best things you can do to take care of your health is to pick a Primary Care Provider (PCP) and visit your PCP for your health care needs. This is called establishing a medical home. When you see this icon, there is information about how to establish a medical home.

Nurse Advice Line

This icon is used to remind you that the 24-Hour Nurse Advice Line is always available to help you if you have medical questions.

MyMolina.com

Molina Healthcare members have access to many online self-services at www.MyMolina.com. MyMolina.com is available 24 hours a day, 7 days a week. You can use MyMolina.com to:

- Change your address or phone number
- Find a Molina Healthcare network provider
- Change your Primary Care Provider (PCP)
- Request a new ID card
- File a complaint

To sign up, visit www.MyMolina.com and click on "Register Now" to create an account.

Holiday Closures

The Molina Healthcare office is closed on the following days:

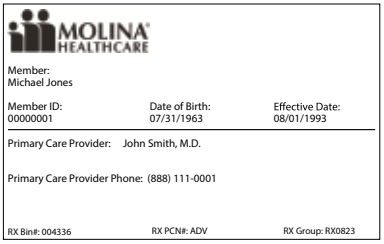
- New Year's Day
- Martin Luther King Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve Day – Open 8:00 a.m. until Noon
- Christmas Day
- New Year's Eve Day – Open 8:00 a.m. until Noon

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.

The Molina Healthcare 24-Hour Nurse Advice Line is still available 24 hours a day, seven days a week to answer questions about your health.

Identification (ID) Cards

When you became a member, you should have received a Molina Healthcare member ID card in the mail. This card replaces your HFS medical card. This card is good for as long as you are a Molina Healthcare member. You will not receive a new card each month as you did with the HFS medical card.



Please check your Member ID Card to make sure the information is correct. On the front of your ID Card will be:

- Your name
- Your date of birth (DOB)
- Your Molina Healthcare member identification number (ID#)
- Your primary care provider's (PCP) name
- Your PCP office phone number
- The identifiers for Molina Healthcare's prescription benefit

On the back of your ID Card will be:

- Member Services phone number
- Molina Healthcare's 24-hour Nurse Advice Line toll-free number
- Authorization Department (for your provider) phone number
- Claims Address (for your provider)

Always Keep Your ID Card With You

You will need your ID card each time you get medical services. This means you need your Molina Healthcare ID card when you:

- See your primary care provider (PCP)
- See a specialist or other provider
- Go to an emergency department
- Go to an urgent care facility
- Go to a hospital for any reason
- Get medical supplies
- Get a prescription
- Have medical tests

If you have not received your ID Card yet, call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

If any of the information on the ID Card is wrong or you lose your ID Card, visit www.MyMolina.com to update your information, print a temporary ID Card or request a new ID Card. You may also call Member Services.

Check to make sure the primary care provider (PCP) listed on your ID card is correct. If the PCP on your ID card is not the PCP you are seeing, visit www.MyMolina.com to change your PCP. You may also call Member Services. The representative will make sure that your provider is a network provider and will send you an updated ID card. If you would like to see a different PCP than the one listed on your ID card visit www.MyMolina.com or call Member Services for help selecting a network provider.

Provider Directory

Molina Healthcare's provider directory is online at www.MolinaHealthcare.com.

- It lists the names, phone numbers and addresses of our network primary care providers
- It lists specialists, urgent care centers, hospitals and other providers in your area.
- You can also use it to find a dentist, pharmacy or vision care provider.

If you need a printed copy of the provider directory, or if you would like help with picking a provider, call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

New Member Information

Transition of Care

If you were on Medicaid fee-for-service the month before you became a Molina Healthcare member and have health care services already prior authorized or scheduled, it is important to call Member Services today or as soon as possible. In certain situations, for a brief time after you enroll, we may allow you to get care from a provider that is not a Molina Healthcare network provider. This is called transition of care. We may allow this to ensure you get the care you need.

We may also allow you to continue to receive services that were authorized by Medicaid fee-for-service. However, you must call Molina Healthcare before you receive the care. If you do not call us, you may not be able to receive the care or the claim may not be paid. For example, call Member Services if you have the following services already authorized or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision care (for example, braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

After you enroll, Molina Healthcare will tell you if any of your current medications require prior authorization (PA) that did not require authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information we provide and contact Member Services if you have any questions.

You can visit www.MolinaHealthcare.com to find out if your medication(s) require prior authorization. You may need to ask your prescribing provider's office to submit a prior authorization request to us if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to Molina Healthcare and it is approved.

Waiver Programs

The Illinois Department of Human Services (DHS) has waiver services available for members who qualify. DHS performs an assessment, called a determination of need (DON), to see if a member qualifies for waiver services. If a member qualifies for waiver services, the member will be able to get additional home and community based services. These services help members live independently. Molina Healthcare covers the waiver services in addition to your medical health care benefits.

Members who qualify will get a Waiver Program Handbook Supplement (Long Term Services and Supports) with more information in their new member welcome packet. The Waiver Program Handbook Supplement is also posted on www.MolinaHealthcare.com.

24-Hour Advice Lines

Nurse Advice Line

Molina Healthcare's Nurse Advice Line is available 24 hours a day, 7 days a week to answer questions that you have about your health. For example, you can call:

- If you have a medical question after your health care provider's normal business hours
- When you do not feel well and you aren't sure what to do
- If you have a follow-up question after a medical appointment
- If you are not sure where to go for care

The phone line is staffed by registered nurses. Many of the nurses are fluent in both English and Spanish.

Molina Healthcare's 24-Hour Nurse Advice Line

English: (888) 275-8750
Español: (866) 648-3537
TTY: (866) 735-2929

Behavioral Health Crisis Line

If you have a behavioral health crisis, call our Behavioral Health Crisis Line. The phone line is available 24 hours a day, 7 days a week.

Molina Healthcare's 24-Hour Behavioral Health Crisis Line

English: (888) 275-8750
Español: (866) 648-3537
TTY: (866) 735-2929

Your Medical Home

One of the most important steps in taking care of your health is establishing a medical home. When you choose a primary care provider (PCP), you are choosing a medical home.

Your PCP is the doctor who will help you with most of your medical needs. Your PCP will give you care, offer advice, and refer you to a specialist when necessary. You have the right to pick a PCP who meets your needs and who you are comfortable with. When you do this, you can develop a lasting relationship that will create a health care partnership for years to come.

Choosing a Primary Care Provider (PCP)

Each Molina Healthcare member must pick a primary care provider (PCP) from Molina Healthcare's provider network. Your PCP is your personal doctor. If you do not pick a PCP, one is assigned to you. Refer to our provider directory for a list of our network providers. Access the provider directory at www.MolinaHealthcare.com.

Your PCP can be:

- An individual physician
- A physician group
- An advanced practice nurse or advanced practice nurse group trained in family medicine (general practice)
- A specialist or an internal medicine practitioner

Your PCP will work with you to direct your health care. Your PCP will treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. 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 Molina Healthcare to discuss.

The *How to Pick a PCP Checklist* on the back cover of this handbook can help you pick a PCP. You may also call Member Services for help in picking a PCP. The PCPs contracted with Molina Healthcare are listed in the provider directory. Access the provider directory online at www.MolinaHealthcare.com.

If you do not pick a PCP, Molina Healthcare will pick one for you. When we pick your PCP for you, we will take your home address and the language you speak into consideration. However, we prefer you pick your own PCP. You are the person who can best make the decision.

Once you have a PCP, schedule a checkup soon, even if you are not sick. During the appointment, you will have a chance to get to know your PCP and to ask questions that will help you develop a good relationship. The First Visit Checklist attached to the back cover of this handbook will help you prepare for your appointment. You can reach your PCP by calling the PCP's office. Your PCP's

name and telephone number are printed on your Molina Healthcare ID card.

If you would like to know more about your PCP or other Molina Healthcare providers, visit www.MolinaHealthcare.com or call Member Services. You can get information about your provider's professional qualifications, such as:

- The medical school he or she attended
- Where he or she completed residency
- Board certification status
- The languages your provider speaks

You can use the Internet to view the provider directory online. Did you know the Internet is free at most public libraries? If you need help learning to use the Internet, ask your librarian. If you would like printed copies of any of the information you see on Molina Healthcare's website, please call Member Services. The information is available in English and can be provided in your primary language on request.

Changing Your PCP

If for any reason you want to change your PCP, you may change your PCP online at www.MyMolina.com or by calling Member Services.

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.
Our network PCPs are listed in our provider directory. Access our provider directory online at www.MolinaHealthcare.com. If you would like help with picking a provider, call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Getting Medical Services

Remember you must receive services covered by Molina Healthcare from in-network facilities and providers. See pages 22-34 for information on services covered by Molina Healthcare. The only time you can use providers that are not on Molina Healthcare's network is for:

- Emergency services
- Qualified Family Planning
- An out-of-network provider that Molina Healthcare has approved you to see

Molina Healthcare network providers are listed in our provider directory. Access the provider directory at www.MolinaHealthcare.com. The provider directory also lists other non-panel providers you can use to receive services.

If you are outside of the Molina Healthcare service area and you need non-emergency medical care, the provider must first contact Molina Healthcare to get approval before providing any services. If you are out of Molina Healthcare's service area, and need emergency care, go to the nearest emergency room. You have the right to go to any place that provides emergency services.

Emergency Services

Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor.

Some examples of when emergency services are needed include:

- Miscarriage/pregnancy with vaginal bleeding
- Seizures or convulsions
- Unusual or excessive bleeding
- Unconsciousness
- Overdose / Poisoning

- Severe burns
- Broken bones
- Chest pain
- Difficulty breathing

If you are not sure if you need to go to the emergency room, call your primary care provider (PCP) or Molina Healthcare's 24-Hour Nurse Advice Line at (888) 275-8750. For Spanish, call (866) 648-3537. For hearing impaired, call TTY at (866) 735-2929 or Illinois Relay Service at 711. Your PCP or our registered nurses can give you advice on what you should do.

We cover emergency care both in and out of the county where you live. Emergency care is available 24 hours a day, 7 days a week. You do not need a referral to receive emergency care. You do not have to contact Molina Healthcare for prior authorization to get emergency care. If you have an emergency, call 911 or go to the NEAREST emergency room. For a list of places providing emergency care, view our provider directory online at www.MolinaHealthcare.com or call Member Services.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of Molina Healthcare, and show them your ID card.
- If the provider who is treating you for an emergency takes care of your emergency, but thinks you need other medical care to treat the problem that caused your emergency, the provider must call Molina Healthcare.
- After an emergency room visit, contact your PCP to make an appointment for follow-up care. Do not go to the emergency room for follow-up care.
- If the hospital has you stay, please make sure that Molina Healthcare is called within 24 hours.

Post-stabilization services are Medicaid-covered services provided after an emergency medical problem is under control. These

services may be used to improve or resolve your condition. They may be provided in a hospital or office setting. For a list of places providing post-stabilization services, view our provider directory online at www.MolinaHealthcare.com or call Member Services.

If you have called 911 or accessed emergency care, you must notify Molina Healthcare WITHIN 24 HOURS, or as soon as reasonably possible, so your care can be coordinated. You can also have a family member or friend call on your behalf.

After-Hours or Non-Emergency Care

During normal business hours, you may call your provider's office to schedule an appointment or ask questions about your care. Your PCP's phone number is on your ID Card. Sometimes your provider's office is closed. Or your provider cannot see you right away. Here are steps you can take to stop your injury or illness from getting worse:

1. Call your PCP for advice. Even if your provider's office is closed, the office has someone available 24 hours a day, 7 days a week who will let you know what to do.
2. If you cannot reach your provider's office, call Molina Healthcare's 24-Hour Nurse Advice Line at (888) 275-8750. For Spanish, call (866) 648-3537. Nurses are always available to answer your questions.
3. Go to a network urgent care center. Network urgent care centers are listed in the provider directory. You do not need permission from a provider to go to an urgent care center. If you visit an urgent care center, always call your PCP after your visit to schedule follow-up care.

Call your dedicated case manager as soon as possible so he or she can help you coordinate your care and assist with any needed follow up.

Where to Go For Medical Services

Quick Reference Chart

Below is a quick reference chart to help you learn where to go for medical services.

Type of Care Needed	Where to Go and Whom to Contact
Emergency care Emergencies may involve, but are not limited to: • Miscarriage/ pregnancy with vaginal bleeding • Seizures or convulsions • Unusual or excessive bleeding • Unconsciousness • Overdose / Poisoning • Severe burns • Broken bones • Chest pain • Difficulty breathing	Call 911 if it is available in your area or go to the nearest emergency department. 911 is the local emergency telephone system available 24-hours a day, 7 days a week. Call the Poison Control Center at (800) 222-1222.

Type of Care Needed	Where to Go and Whom to Contact
Urgent care and non-emergency treatment When you need care right away, but you are not in danger of lasting harm or losing your life For an illness or injury, such as a sore throat, the flu or a headache	Call your PCP to request an appointment. You can expect an appointment within two days of the date you called. Even if your PCP's office is closed, your PCP will have an answering service available 24 hours a day, 7 days a week. Leave a message and someone will call you back and tell you what to do. You can also go to an urgent care center if you have an urgent need and your provider cannot see you right away. For urgent care centers near you, visit our provider directory online at www.MolinaHealthcare.com.
Routine Care Such as an annual checkup, physical exam, wellness visit or immunizations	Call your PCP to request an appointment. You can expect an appointment within five weeks of the date you called.
Family Planning and Women's Health Services	You do not need a referral to receive Women's Health or Family Planning Services. You can go directly to your PCP, a Women's Health Care Provider (WHCP) listed in the provider directory, Certified Nurse Midwife, or Qualified Family Planning Provider to receive these services. You can expect an appointment within five weeks of the date you called.
Specialist appointments	Call your PCP first. Your provider will give you a referral if needed. You should get an appointment within eight weeks of the date you called.

Type of Care Needed	Where to Go and Whom to Contact
Behavioral Health, Mental Health and Substance Abuse Services	Access our provider directory online at www.MolinaHealthcare.com to find a network provider near you. Contact Molina Healthcare for authorization to see a network behavioral health provider. You may also call or see a Community Mental Health Center, or any Division of Mental Health (DMH), Division of Alcoholism and Substance Abuse (DASA) or Illinois Department of Human Services (DHS) facilities.

Care Coordination Program

Molina Healthcare's care coordination program can help you get the care and medical services you need. The professionals who work in the care coordination program are called case managers, also known as care coordinators. All case managers are nurses or social workers. As a Molina Healthcare member, you will have a dedicated case manager to assist you.

To help you, we will need to learn more about you. Soon after you become a Molina Healthcare member, we will call you to get you know you. We will ask you questions about your health and lifestyle. This is called a health assessment. The assessment will help us determine how care coordination can assist you. We will complete a health assessment as often as needed, but at least once a year.

Your case manager will work with your providers, other health care professionals and support staff to create and update your care plan. Your care plan is a written plan that details needed medical and other services to manage your health care needs. These professionals make up your integrated care team. The integrated care team will help everything run smoothly by bringing together the health care and additional assistance services you need to manage your health. Several times a year, your case manager will

contact you. He or she will review your care plan and make sure you are getting the care you need. We will work with you either face-to-face or by telephone.

Care coordination is especially helpful if you have difficulty controlling a medical condition or multiple medical conditions that require 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 be connected to your case manager, call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711) and a representative will be able to connect you.

If you do not want to be in the care coordination program, call Member Services and tell us you do not want to be part of the program.

Notify Molina Healthcare if you learn that you are pregnant so that you get all of the information and support that you will need for a healthy pregnancy.

Covered Services by Molina Healthcare

Molina Healthcare covers all medically necessary Medicaid-covered services. The services covered by Molina Healthcare are covered at no cost to you. The Summary of Benefits Chart helps you know which services are covered. Some limitations and prior authorization requirements may apply.

Most services are available to you without any prior authorization (PA). Some services do require PA. For a PA, a provider must call Molina Healthcare and tell us about the care he or she wants you to receive. Molina Healthcare reviews the request and lets your provider know if the request is authorized before your provider gives you the service. This is done to ensure you get appropriate health care services.

If you have questions about a PA request, call Member Services. Molina Healthcare staff is available to help you between 8:00 a.m. and 5:00 p.m., Monday through Friday. After business hours, you can leave a message. Your call will be answered the next business day.

There are other times when your primary care provider (PCP) may give you a referral. A referral is a request from a PCP for you to see a specialist. A specialist is a provider who focuses on a particular kind of health care. To receive care from a specialist, your PCP must refer you. This also ensures your care is coordinated.

Your PCP will submits PAs on your behalf and refer you to specialists when needed. So, it is important for you to develop a good relationship with your provider. This helps to ensure your PCP gives you the best care for your needs.

Molina Healthcare covers medically necessary Medicaid-covered services in a timely manner from out-of-network providers if there are no network providers available to provide the services. Molina Healthcare covers this at no cost to you.

Summary of Benefits Chart

Molina Healthcare covers medically necessary Medicaid-covered services. This chart is a complete list of services Molina Healthcare covers. It also helps you know services that require PA. If you have any questions, call Member Services.

Service	Coverage & Benefit Limitations	Prior Authorization
Advanced Practice Nurse services	Covered benefit	
Ambulatory surgery	Covered benefit	Some ambulatory surgeries require PA.
Chiropractic services	Limited to members 19 and 20 years of age for the treatment of the spine by manual manipulation.	Requires PA.
Dental services	Dental services, including oral surgery, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling), for members 19 and 20 years of age. Dental exams (1 per year for members 19 and 20 years of age). One cleaning every six months for members 19 and 20 years of age. One cleaning per calendar year for members 21 years of age and older. Practice visits for individuals with developmental disabilities and serious illness. Adult dental services are limited to emergencies.	

Emergency dental services	Covered benefit	
Diagnostic services (X-ray, lab)	Covered benefit	Selected diagnostic services (including CT scans, MRIs, MRAs, PET Scans, and SPECT) require PA.
Durable Medical Equipment (DME)	Covered benefit	Some durable medical equipment items require PA.
Emergency services	Covered benefit	PA is not required.
EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services	Covered for members 19 and 20 years of age.	
Family planning services and supplies	Covered benefit	Some family planning services and supplies require PA.
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Covered benefit	
Hearing (audiology) services, including hearing aids	Covered benefit	Requires PA.
Home health services	Covered benefit	Requires PA.

Hospice care (care for terminally ill)	Covered benefit	
Inpatient hospital services	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 (Waiver Services)	Determination of need must be completed specifically for individuals eligible for specific waiver programs. Refer to the Waiver Program Handbook Supplement for coverage information.	
Medical supplies	Covered benefit	Some medical supplies require PA.

Mental health and substance abuse services	Covered benefit	PA is not required for services received at an in-network: • Community mental health center • Division of Mental Health (DMH) facility • Division of Alcoholism and Substance Abuse (DASA) facility, or • Illinois Department of Human Services (DHS) facility Services require PA after 20 visits per year if received at facilities other than a community mental health center or DMH, DASA or DHS facilities.
Nursing facility services	Covered benefit Also covered for members ages 19 and 20 who are not in the Medically Fragile Technology Dependent (MFTD) Waiver, with the purpose of transitioning the member from a hospital to the home or other appropriate setting.	Short-term inpatient rehabilitative nursing facility stays require PA.

Obstetrical (maternity care: prenatal and postpartum including at-risk pregnancy services) and gynecological services.	Covered benefit Women may self-refer Practice visits for individuals with developmental disabilities and serious illness.	PA is not required.
Outpatient hospital services	Covered benefit	Some outpatient services require PA.
Physical and occupational therapy	Limited to 20 services per year	Outpatient services require PA after the initial evaluation and six visits. Services provided in the home require PA after the initial evaluation and three visits.
Podiatry (foot) services	All podiatry services are covered for members 19 and 20 years of age. For individuals 21 years of age and older with Diabetes, one visit is covered every 60 days.	
Post-stabilization services	Covered benefit	
Practice Visits	Covered benefit for enrollees with Special Needs	
Prescription drugs, including certain prescribed over-the-counter drugs	Covered benefit 30-day supply of prescription drugs mailed to your home	Selected drugs, including injectables and some over-the-counter drugs, require PA.

Preventive mammogram (breast) and cervical cancer (pap smear) exams.	Covered benefit	PA is not required.
Primary care provider (PCP) services	Covered benefit	PA is not required.
Renal dialysis (kidney disease)	Covered benefit	PA is not required.
Respiratory equipment and supplies	Covered benefit	
Specialist services	Covered benefit PCP referral required to see all specialists, except women's health care providers	Office visits to see a network specialist do not require PA. Some specialist services require PA.
Speech therapy services	Limited to 20 services per year	Requires PA.
Transportation to covered services	Covered benefit	Requires PA.
Vision (optical and optometrist) services, including eyeglasses	One exam per year One pair of glasses in a two-year period No restrictions on replacement glasses for members 19 and 20 years of age Members 21 years of age and older are limited to replacement lenses when medically necessary	Requires PA.
Yearly well-adult exams	Covered benefit	PA is not required.

Dental Benefits

Taking care of your teeth and gums keeps you healthy. Visiting your dentist regularly helps prevent cavities and other problems with your teeth. Refer to our provider directory to find a Molina Healthcare network dentist. Access the provider directory at www.MolinaHealthcare.com.

Molina Healthcare covers dental services, including oral surgeons, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling), for members 19 and 20 years of age. Molina Healthcare covers 1 dental exam per year and one cleaning every six months for members 19 and 20 years of age.

As an additional benefit, Molina Healthcare covers one cleaning per year for members 21 years of age and older.

As an additional benefit, we also cover practice visits to the dentist for individuals with developmental disabilities and serious illness.

Otherwise, adult dental services are limited to emergencies.

If you have any questions about your dental benefits, please call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Vision Benefits

To help keep your eyes healthy, Molina Healthcare covers one eye exam per year for all members. We also cover one pair of eyeglasses (frames and lenses) every two years.

Members 21 years of age and older are limited to replacement eyeglasses when medically necessary. Members 19 and 20 years of age have no restrictions on replacement eyeglasses.

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

If you have any questions about your vision benefits, please call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Prescription Drugs

Molina Healthcare covers your prescriptions when you get them filled at a Molina Healthcare network pharmacy. While Molina Healthcare covers all medically necessary Medicaid-covered medications, we use a preferred drug list (PDL). These are the drugs that we prefer that your provider prescribe.
To get the medication you need, you need a prescription from your provider. To fill or refill your prescriptions, take your prescription to a network pharmacy. Show the pharmacy your Molina Healthcare ID card. As long as you use a network pharmacy and your medication is on the PDL or prior authorized, you will not need to pay for your medication.

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

To be sure you are getting the care you need, we may request that your provider submit information to us (a prior authorization request). They will be asked to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior authorize a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first.

Some drugs may also have quantity (amount) limits and some drugs are never covered. Some drugs that are never covered are:

- Drugs for weight loss
- Drugs for erectile dysfunction
- Drugs for infertility

If we do not approve a prior authorization (PA) request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing.

When you become a Molina Healthcare member, we will tell you if any of your current medications require prior authorization (PA) that did not require authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information we provide and contact Member Services if you have any questions. You can visit www.MolinaHealthcare.com to find out if your medication(s) require prior authorization. You may need to ask your prescribing provider's office to submit a prior authorization request to us if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to Molina Healthcare and it is approved.

Molina Healthcare requires the use of generic drugs if they are available. If your provider believes you need a brand name drug, the provider may submit a PA request to Molina Healthcare. Molina Healthcare will review the request and determine whether to approve the brand name medication. If you plan to travel out-of-state, be sure to fill your prescriptions before you leave.

For a list of our PDL, which includes the list of covered over-the-counter drugs, and the list of medication that require prior authorization,

- Visit our website at www.MolinaHealthcare.com
- Call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711)

Our PDL and list of medications that require prior authorization can change. Thus, it is important for you and your provider to check this list when you need to fill or refill a medication.

Refer to our provider directory to find a Molina Healthcare network pharmacy. Access our provider directory online at www.MolinaHealthcare.com. You can also call Member Services for help in finding a network pharmacy near you. Remember, Molina Healthcare will only pay for prescriptions you get from a Molina Healthcare pharmacy network.

Behavioral Health & Substance Abuse Services

Molina Healthcare covers behavioral health services and treatment for substance abuse. You can get services or receive treatment from providers in our network. Your PCP can refer you to a behavioral health provider.

We cover behavioral health services, such as:

- Mental health assessments and/or psychological evaluations
- Medication management

We cover treatment for substance abuse, such as:

- Outpatient treatment
- Detoxification
- Psychiatric evaluation services
- Day treatment

If you need behavioral health or substance abuse services:

- See your PCP for a referral
- Call Member Services for information at (855) 766-5462 (TTY/Illinois Relay Service 711)
- Or, you may self-refer directly to an in-network mental health facility , such as a
  - Community Mental Health Center, or
  - In-network Division of Mental Health (DMH), or
  - Division of Alcoholism and Substance Abuse (DASA), or
  - Illinois Department of Human Services (DHS) facility

Our network providers and facilities are listed in the provider directory. Access our provider directory online at www.MolinaHealthcare.com.

If you have a behavioral health crisis, call our **Behavioral Health Crisis Line** at (855) 766-5462. Select Option 2. Then select Option 9. Help is available 24 hours a day, 7 days a week.

Transportation

If you need transportation to and from your doctor's office to receive covered health care services, Molina Healthcare can provide transportation if deemed necessary. This transportation benefit is for Medicaid-covered services. Medical appointments include trips to:

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

To arrange transportation, or if you have any questions, please call (877) 917-8164. Please call as soon as possible to schedule your transportation, but no later than 72 hours in advance of your appointment.

As an additional benefit, Molina Healthcare also covers a trip to the pharmacy to pick up a prescription right after a medical appointment. Please call the ride assist line at (877) 917-8164 to schedule your pharmacy stop prior to leaving your provider's office. Ask your health care provider to call your prescription in to the pharmacy so it is ready when you get there. Let your transportation driver know you need to stop at the pharmacy on your return trip.

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.

Disease Management Programs

If you are living with a chronic health illness or behavioral health illness, Molina Healthcare has Disease Management Programs that can help. The programs are free. They provide learning materials, advice and care tips. You are automatically enrolled 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 to give you the right care and advice.

- You can also be referred to a program through a self-referral or a provider.
- You must meet certain requirements to be in the programs.
- It is your choice to be in a program and you can ask to be removed from a program at any time.

Please call our Health Management Department at (866) 891-2320 to learn more about the programs. You can also find out if you are already enrolled in one. You can also ask for a referral or ask to be removed from a program.

Motherhood Matters℠

Molina Healthcare has a special program for our members who are pregnant. The Motherhood Matters℠ program:

- Helps you get the education and services you need for a healthy pregnancy.
- Reminds you when to get prenatal care.
- Reminds you when it's time for your baby to see the doctor.

Contact Members Services to enroll. You will receive a Motherhood Matters℠ packet that has helpful tips and information about getting care for you and your baby.

Services Not Covered
by Molina Healthcare or Illinois Medicaid

Molina Healthcare does not pay for services or supplies received by a member who does not follow the directions in this handbook. Molina Healthcare does not pay for the following services, which are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- All services or supplies that are not medically necessary
- Comfort items in the hospital (e.g., TV or phone)
- Diagnostic and therapeutic procedures related to infertility or sterility
- Inpatient hospital custodial care
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid
- Medical and surgical services that are provided solely for cosmetic purposes
- Services for the treatment of obesity, unless determined medically necessary
- Paternity testing
- Services that are provided by a non-Affiliated Provider and not authorized by Molina, unless it is specifically required that such services be Covered Services
- Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment
- Services that are provided through a Local Education Agency (LEA)
- Services that are provided without a required Referral or prior authorization as set forth in the Provider Handbook
- Services to find cause of death (autopsy)
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure

This may not be a complete list of the services that are not covered by Medicaid or Molina Healthcare. For questions or more information, call Member Services.

Quality Care

Molina Healthcare wants you to receive the best quality of care. We have a Quality Improvement (QI) Program to ensure you get quality care. Each year, we set goals to improve our services. We want to ensure your health care needs are being met. We also want you to be happy with the services you get from Molina Healthcare and our network providers. We do many studies during the year to find areas for improvement and take steps to bring you higher quality care and better service. This process is called "quality improvement."

The process also includes planning, starting, watching and reporting on programs. We do this to be sure that your safety and health needs are being met. Some of these programs include:

- Mailing reminders to women that explain the need for pap tests, Chlamydia screenings and mammograms
- Postcards/phone calls reminding members to receive and follow their care plans for various conditions and health concerns: diabetes, asthma, and smoking cessation
- Member satisfaction surveys on the healthcare and services that you have received
- Investigating complaints about quality of care or services

Your Feedback is Important to us

Molina Healthcare makes every effort to give you and your family the best care. Your satisfaction with Molina Healthcare is very important to us. You may receive a survey in the mail or by telephone asking questions about how happy or unhappy you are with the services you are getting. Please take the time to respond. We value your opinion. It will help us improve the service we provide.

Molina Healthcare welcomes suggestions on how to serve you better. If you have suggestions, please call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Advisory Committees

Molina Healthcare values your opinion! That is why we ask our members to participate in advisory committees. We hold meetings four times a year in our service area region.

Molina Healthcare has two advisory committees:

- Enrollee Advisory Committee
- Bridge2Access Advisory Committee

For a little of your time, you can help us better serve you. For more information, call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Evaluating New Health Care Treatments

Molina Healthcare is always looking for ways to take better care of our members. That is why Molina Healthcare has a process to look at new medical technology, drugs, and devices as possible added benefits. Our Medical Directors find new medical procedures, treatment, drugs and devices when they become available. They present research information to Molina Healthcare's Utilization Management Committee. Physicians review the technology. The physicians then suggest whether it can be added as a new treatment for Molina Healthcare members.

If Molina Healthcare denies coverage for any device, protocol, procedure or other therapy that is a new technology and is not a Medicaid-covered service, you or your provider can ask for information on Molina Healthcare's coverage protocols and procedures. For more information, please call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

How Molina Healthcare Pays for Your Care

Molina Healthcare contracts with providers in several different ways:

- Molina Healthcare network providers are paid on a fee-for-service basis. This means they are paid each time they see you, or for each procedure they perform
- Some providers who are paid a flat amount for each month that a member is assigned to their care, whether the member sees the provider or not
- Some providers may be offered incentives for giving good preventive care
- Some providers may be offered incentives for monitoring the use of hospital services
- Molina Healthcare does not reward providers or employees for denying medical coverage or services
- Molina Healthcare does not provide financial incentives for utilization management decisions that could result in denials or underutilization
- Utilization Management decision-making is based only on appropriateness of care and service and existence of coverage

You can contact Molina Healthcare to get information such as:

- The structure and operation of Molina Healthcare
- How we pay our providers

If you have any ideas for changes, please call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).

Your health coverage is subject to change or be modified by government regulatory agencies. Molina Healthcare will notify you of any changes as they occur.

What If I Get a Bill?

Molina Healthcare members do not have to pay co-payments or other charges for medical care. If you get a statement from a provider, check to see if it says you owe any money. This may also be listed as "patient responsibility." If the statement shows that you are responsible for any charges or it asks you to sign an agreement to pay for services, call Member Services right away.

You can also report this to Molina Healthcare's Compliance department by phone, email or online.

Confidential Compliance Hotline: 1-866-606-3889
Email: MHILCompliance@MolinaHealthcare.com
Online: https://molinahealthcare.Alertline.com

See the Fraud and Abuse section in this handbook for more information about reporting fraud and abuse.

If the letter does not say you owe money, this means you got a statement, not a bill. The statement is showing you that Molina Healthcare was billed for the services you got. These statements usually note at the top of the page that "this is not a bill." You do not need to do anything. You may keep the statement for your records. The provider is not billing you for the services. If you did not see your doctor for the services listed in the statement, please call and report this to Member Services right away.

Your Membership Rights

As a member of Molina Healthcare, you have the following rights:

- To receive all the services that Molina Healthcare is required to provide.
- To exercise your rights and to be assured that exercising those rights does not adversely affect the way Molina Healthcare, its providers or the Illinois Department of Healthcare and Family Services (HFS) treats you.

- To be treated with respect and with due consideration of your dignity and privacy by everyone who works with Molina Healthcare.
- To receive information about Molina Healthcare, Molina Healthcare's providers, Molina Healthcare's doctors, Molina Healthcare's services and your rights and responsibilities.
- To choose or change your primary care provider (PCP) from Molina Healthcare's network.
- To receive information about your health including available treatment options and alternatives regardless of cost or benefit coverage. Information must be presented in a manner appropriate to your condition and ability to understand.
- To participate in decisions regarding your health care, including the right to refuse treatment.
- To privacy. Molina Healthcare keeps your medical records private in accordance with state and federal laws.
- To request and receive a copy of your medical records, and request that they be amended or corrected.
- To complain about Molina Healthcare or your care by calling, faxing, e-mailing or writing to Member Services.
- To be informed of your right to a fair hearing and to file grievances and appeals. You have the right to appeal Molina Healthcare's decisions. You have the right to have someone speak for you during the grievance.
- To receive written notification when health care services are reduced, suspended, terminated or denied. The notification contains instructions on how to file a grievance or request a Fair Hearing from HFS.
- To disenroll from Molina Healthcare.
- To ask for a second opinion about your health condition.
- To ask for an external independent review of experimental or investigational therapies.
- To appeal or file directly with the United States Department of Health and Human Services Office of Civil Rights any complaints of discrimination on the basis of race, color, national origin, age or disability in the receipt of health services.
- To receive information about Molina Healthcare's structure and operations, their providers, or your health in your

preferred language. You have the right to request information in printed form translated into your preferred language free of cost.

- To request and receive informational materials in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
- To make decisions concerning your medical care including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience.
- To exercise these rights without negatively affecting how you are treated by Molina Healthcare, Molina Healthcare's providers or HFS.
- To make recommendations regarding the organization's member rights and responsibilities policies.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, or convenience used to pressure, punish or seek revenge.
- To seek emergency care and use any hospital or other setting for emergency services.
- To receive oral interpretation and translation services free of charge.
- To make advance directives.
- To receive written information on advance directives policies and changes to State law as soon as possible, but no later than 90 days after the proposed effective date of the change.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Illinois Department of Human Services Bureau of Customer Support and Services with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services.
- To change your primary care physician (PCP) or Women's Health Care Provider (WHCP) to another PCP within 30 days after the receipt of the request.
- To receive family planning services, from any qualified Medicaid provider in or out of Molina Healthcare's network of providers.

- To cultural considerations. Molina Healthcare participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- To be provided with procedures for obtaining benefits, including authorization requirements.
- To be notified when a provider has been terminated from the Molina Healthcare network.
- To have your rights communicated to your providers.
- To receive notice of action regarding your appeals. You also have the right to see or request a copy of the information that Molina Healthcare used to make this decision. You have the right to keep getting the service during the appeal process, however if the appeal is denied you may have to pay for those services.
- To exercise your Appeal or Grievance rights. Molina Healthcare may not take an action in connection with an Enrollee who is exercising these rights. Any attempts to seek to terminate enrollment in violation of Section 4.13.5 will be considered a breach of contract.
- To be provided with the procedures to be followed to file an appeal, grievance or state hearing.

Your Membership Responsibilities

As a member of Molina Healthcare, you have the responsibility:

- To call Molina Healthcare within 24 hours of a visit to the emergency department or an unexpected stay in the hospital.
- To provide information to your doctor or Molina Healthcare that is needed to provide decisions about your health care.
- To be active in decisions about your health care.
- To follow the care plans and instructions for care that you have agreed upon with your doctor(s).
- To build and keep a strong patient-doctor relationship. You have the responsibility to cooperate with your doctor and staff. This includes being on time for your visits or calling your doctor if you need to cancel or reschedule an appointment.

- To present your Molina Healthcare ID Card and HFS medical card when receiving medical care and report any fraud or wrong doing to Molina Healthcare or the proper authorities.
- To understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- To inform Member Services of any change of address or any changes to entitlement that could affect continuing eligibility.

Concerns and Complaints

Molina Healthcare may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services in the receipt of health services. If you think you have not been treated fairly, please call Member Services.

How to Let Molina Healthcare Know if you are Unhappy or Do Not Agree with a Decision We Made

If you are unhappy with anything about Molina Healthcare or its providers, you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you such as a family member or provider, can contact us.

If you want someone to speak for you, you will need to let us know this. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and that he or she will file an appeal for you.

To contact us you can:

- Call Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711).
- Fill out the Member Grievance and Appeal Request form in the back of the member handbook.
- Call Member Services to request that they mail you a form.
- Visit our website at www.MolinaHealthcare.com.

- Write a letter telling us what you are unhappy about. Be sure to include your first and last name, your member ID number on front of your Molina Healthcare member ID card, your address and your telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain what you are unhappy about.

Mail the form or your letter to:

Molina Healthcare of Illinois
Attn: Appeals and Grievances Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523

Grievances and Appeals

Grievances

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.

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.

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 Member Services at (855) 766-5462 (TTY/Illinois Relay Service 711)
- Filling out the Member Grievance and Appeal Request form in the back of the member handbook and mailing it to us. The form is also available on our website and by calling Member Services.
- You can also file your grievance by writing a letter. Then, send your letter via mail or fax. 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.

Molina Healthcare of Illinois
Attn: Appeals and Grievances Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523
Fax: 630-571-1220

You can ask us to help you file your grievance by calling Member Services.

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 try to resolve your grievance right away. If we cannot, it will go to our Grievance Committee. We may contact you for more information. The Grievance Committee will make a recommendation within sixty (60) calendar days from the date you filed your grievance. You will get a letter from Molina Healthcare with our resolution.

Appeals

Molina Healthcare will send you a letter in writing, called a Notice of Action letter, if we make a decision to:

- Deny a request to cover a service for you
- Reduce, suspend or stop services before you receive all of the services that were approved, or
- Deny payment for a service you received that is not covered by Molina Healthcare

You may not agree with a decision or an action made by Molina Healthcare about your services or an item you requested. If you do not agree, you may contact us to submit an appeal. 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 Notice of Action letter. 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 Notice of Action letter. 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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped , you will get a Notice of Action letter from us. This 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.

Here are two ways to file an appeal.

1. Call Member Services at (855) 766-5462. 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
Attn: Appeals and Grievances Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523
Fax: (630) 571-1220

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 are hearing impaired, call the Illinois Relay at 711.

Can someone help 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 PCP or a family member, for example.
- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at (800) 641-3929 or for hearing impaired, TTY (888) 460-5111.

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 www.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 Notice of Action, 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 Notice of Action, 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 Notice of Action 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) 766-5462.

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 **thirty (30) 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.

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.
- 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
401 S. Clinton Street, 6th Floor
Chicago, IL 60607
Fax: (312) 793-2005
Or Call (855) 418-4421
For hearing impaired, TTY at (800) 526-5812

- If you want to file a State Fair Hearing Appeal related to 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
401 S. Clinton Street, 6th Floor
Chicago, IL 60607
Fax: (312) 793-8573
Or Call (800) 435-0774
For hearing impaired, TTY at (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.

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.

- You have the right to bring a friend or relative to any appeal hearing. If you need special help for a disability or for English translation please call (855) 766-5462. Please call a Molina Healthcare Member Advocate at (855) 766-5462 if you:
- Need help filing an appeal.
- Need help requesting a fair hearing.
- Want to know more about your rights.

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 your request to reset your hearing is denied, you will receive a letter in the mail informing you of the 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. 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 and Grievances Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523
Fax: (630) 571-1220

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 over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at (855) 766-5462. 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 and Grievances Department
1520 Kensington Road, Suite 212
Oak Brook, IL 60523

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 also 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.

Your Medicaid Eligibility and Coverage

Annual Open Enrollment Period

After one year of enrollment, you can change your health plan if you want to. You do not have to do anything if you want to stay with Molina Healthcare.

At least 90 days before your anniversary date of enrollment, you will get a letter from Illinois Client Enrollment Services (ICES). The letter will say you can pick another health plan if you want. The letter will include the dates you can make the change and instructions on how to change. After you get the letter, you will have 60 days to make a change. This 60-day period 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 instructions in the letter you receive from the ICES. If you do not want to change, you do not need to do anything. Your membership with Molina Healthcare will continue.

Loss of Coverage and Reinstatement

Loss of Medicaid Eligibility

It is important to respond to requests for information from the Illinois Department of Healthcare and Family Services (HFS). You can lose your Medicaid eligibility if:

- You miss an appointment
- You do not give HFS information they requested

If this would happen, HFS would tell Molina Healthcare to stop your membership as a Medicaid member. That means you would no longer be covered by Molina Healthcare.

Loss of Insurance Notice (Certificate of Creditable Coverage)

Any time you lose health insurance, you should receive a notice. This notice is called a Certificate of Creditable Coverage. It is from your old insurance company. The notice says that you no longer have insurance. It is important that you keep a copy of this notice. You might be asked to provide a copy of this notice.

Automatic Renewal of MCO Membership

If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically become a Molina Healthcare member again.

Accidental Injury or Illness

If you have to see a doctor for a problem that was caused by another person or business, you must call Member Services. Another insurance company might have to pay the medical bill.

Some examples of accidental injury or illness are:

- Car accidents
- Dog bites
- A fall in a store

When you call Member Services, we will need:

- The name of the person at fault.
- The name of the person's insurance company.
- The name(s) of any attorneys involved.

Protecting Your 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. We want to let you know how your information is used or shared.

Your Protected Health Information

PHI means *protected health information*. PHI is health information that includes your name, member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share our Members' PHI?

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

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does Molina protect your PHI?

Molina uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways Molina protects PHI:

- Molina has policies and rules to protect PHI.
- Molina limits who may see PHI. Only Molina staff with a need to know PHI may use it.

- Molina staff is trained on how to protect and secure PHI.
- Molina staff must agree in writing to follow the rules and policies that protect and secure PHI
- Molina secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What must Molina do by law?

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices.

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way.

The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. Our Notice of Privacy Practices is in the following section of this document. It is on our web site at www.molinahealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department at (855) 766-5462.

Notice of Privacy Practices Molina Healthcare of Illinois

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Molina Healthcare of Illinois ("**Molina Healthcare**", "**Molina**", "**we**" or "**our**") uses and shares protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private and to follow the terms of this Notice. The effective date of this Notice is September 23, 2013.

PHI stands for these words, *protected health information*. PHI means health information that includes your name, Member number or other identifiers, and is used or shared by Molina.

Why does Molina use or share your PHI?

We use or share your PHI to provide you with health care benefits. Your PHI is used or shared for treatment, payment, and health care operations.

For Treatment

Molina may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

For Payment

Molina may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about

medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

For Health Care Operations

Molina may use or share PHI about you to run our health plan. For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve Member concerns. Your PHI may also be used to see that claims are paid right.

Health care operations involve many daily business needs. It includes but is not limited to, the following:

- Improving quality;
- Actions in health programs to help Members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Address Member needs, including solving complaints and grievances.

We will share your PHI with other companies ("**business associates**") that perform different kinds of activities for our health plan. We may also use your PHI to give you reminders about your appointments.

We may use your PHI to give you information about other treatment, or other health-related benefits and services.

When can Molina use or share your PHI without getting written authorization (approval) from you?

The law allows or requires Molina to use and share your PHI for several other purposes including the following:

Required by law

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

Public Health

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

Health Care Oversight

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

Research

Your PHI may be used or shared for research in certain cases.

Legal or Administrative Proceedings

Your PHI may be used or shared for legal proceedings, such as in response to a court order.

Law Enforcement

Your PHI may be used or shared with police to help find a suspect, witness or missing person.

Health and Safety

Your PHI may be shared to prevent a serious threat to public health or safety.

Government Functions

Your PHI may be shared with the government for special functions.

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

Workers Compensation

Your PHI may be used or shared to obey Workers Compensation laws.

Other Disclosures

Your PHI may be shared with funeral directors or coroners to help them do their jobs.

When does Molina need your written authorization (approval) to use or share your PHI?

Molina needs your written approval to use or share your PHI for a purpose other than those listed in this Notice. Molina needs your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

What are your health information rights?

You have the right to:

• Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use Molina's form to make your request.

• Request Confidential Communications of PHI

You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use Molina's form to make your request.

• **Review and Copy Your PHI**

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions as a Molina Member. You will need to make your request in writing. You may use Molina's form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases we may deny the request.

Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

• **Amend Your PHI**

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a Member. You will need to make your request in writing. You may use Molina's form to make your request. You may file a letter disagreeing with us if we deny the request.

• **Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

- for treatment, payment or health care operations;
- to persons about their own PHI;
- sharing done with your authorization;
- incident to a use or disclosure otherwise permitted or required under applicable law;
- PHI released in the interest of national security or for intelligence purposes; or
- as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period.

You will need to make your request in writing. You may use Molina's form to make your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Member Services Department at (855) 766-5462.

What can you do if your rights have not been protected?

You may complain to Molina and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

You may file a complaint with us at:

Molina Healthcare of Illinois
Member Services
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
(855) 766-5462

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
(800) 368-1019; (800) 537-7697 (TDD);
(312) 886-1807 (FAX)

What are the duties of Molina?

Molina is required to:

- Keep your PHI private;
- Give you written information such as this on our duties and privacy practices about your PHI;
- Provide you with a notice in the event of any breach of your unsecured PHI;
- Not use or disclose your genetic information for underwriting purposes;
- Follow the terms of this Notice.

This Notice is Subject to Change

Molina reserves the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, Molina will post the revised Notice on our web site and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by Molina.

Contact Information

If you have any questions, please contact the following office:

Molina Healthcare of Illinois
Member Services
1520 Kensington Rd., Suite 212
Oak Brook, IL 60523
(855) 766-5462

Membership Termination

Sometimes there may be a special reason that you need to end your health plan membership. Before you can ask for a membership termination you must first call your Managed Care Organization and give them a chance to resolve the issue. If they cannot resolve the issue, you can ask for a termination at any time if you have one of the following reasons:

1. You move and your current MCO is not available where you now live and you must receive non-emergency medical care in your new area before your MCO membership ends.
2. The MCO does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time, and all the services aren't available on your MCO's panel.

4. You have concerns that you are not receiving quality care, and the services you need are not available from another provider on your MCO's panel.
5. Lack of access to Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your MCO's panel, and he/she was the only PCP on your MCO's panel that spoke your language and was located within a reasonable distance from you. Another health plan has a PCP on their panel that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. Other-if staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to end your membership by calling Illinois Client Enrollment Services (ICES) at (877) 912-8880 (TTY/Illinois Relay Service 711). ICES will review your request to end your membership and decide if you meet disenrollment cause. You will receive a letter in the mail to tell you if ICES will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another Managed Care Organization to receive your health care unless ICES tells you differently.

Ending Your MCO Membership

As a member of a Managed Care Organization, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment period for your area. Illinois Client Enrollment Services (ICES) will send you something in the mail to let you know when your annual open enrollment period will be. If you live in a mandatory enrollment, however, area you will have to choose another Managed Care Organization to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment period for your area, you can call Illinois Client Enrollment Services (ICES) at (877) 912-8880 (TTY/Illinois Relay Service 711). Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another Managed Care Organization, your new plan will send you information in the mail before your membership start date.

Choosing a New Plan

After the initial enrollment period, once each twelve months, each enrollee shall have a 60 day period in which to change the MCO in which the enrollee is enrolled. If you are thinking about ending your membership to change to another health plan, you should learn about your choices, especially if you want to keep your current doctor. Remember, each health plan has its own list of doctors and hospitals that it will allow you to use. Each health plan also has written information which explains the benefits it offers and the rules that it has. The 60-day Open Enrollment Period for each Enrolled member shall begin ninety (90) calendar days prior to the member's Anniversary Date. No later than ninety-five (95) calendar days prior to the member's Anniversary Date, the ICES sends notice to each enrolled member about their opportunity to change MCOs and the 60-day deadline for doing so. If the member selects a different MCO during the Open Enrollment Period, enrollment in the new MCO will be effective on the Enrollee's Anniversary Date. Enrollees who make no selection will continue to be enrolled with the same MCO. Enrollees may not change their MCO at any time other than during the Open Enrollment period.

If you would like written information about a health plan you are thinking of joining, or if you simply would like to ask questions about the health plan, you may either call the plan or call Illinois Client Enrollment Services (ICES) at (877) 912-8880 (TTY/Illinois Relay Service 711). You can also find information about the health plans in your area by visiting ICES' website at www.EnrollHFS.Illinois.gov.

Exclusions – Individuals that are not permitted to join an MCO

Seniors and Persons with Disabilities (SPD) individuals are not permitted to join an MCO if they are:

- Individuals 18 years of age or younger
- Participants eligible for Medicare Part A, or enrolled in Medicare Part B
- American Indians and/or Natives of Alaska (may voluntarily enroll)
- Participants of Spenddown
- All Presumptive Eligibility (temporary benefits) Categories
- Participants in the Illinois Breast and Cervical Cancer Program or
- Participants with high-level private health insurance (also known as Third Party Liability or TPL)
- If you believe that you meet any of the above criteria and should not be a member of a MCO, or are a member of a federally recognized Indian tribe and do not want to be a member, call Illinois Client Enrollment Services (ICES) at (877) 912-8880 (TTY/Illinois Relay Service 711). If you meet the above criteria, your MCO membership will be ended.

Can Molina Healthcare End My Membership?

Molina Healthcare may ask the Illinois Department of Healthcare and Family Services (HFS) or Illinois Client Enrollment Services (ICES) to end your membership for certain reasons. HFS/ICES must okay the request before your membership can be ended.

The reasons that Molina Healthcare can ask to end your membership are:

- For fraud or misuse of your Molina Healthcare member ID card.
- For disruptive or uncooperative behavior to the extent that it affects the MCO's ability to provide services to you or other members.
- Inability to furnish Covered Services to the Enrollee's special needs and/or to other Enrollees.
- The member no longer resides in the Contracted area.

Things to Keep in Mind If You End Your Membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use Molina Healthcare doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan's Member Services. If they are unable to help you, call Illinois Client Enrollment Services (ICES) at (877) 912-8880(TTY/Illinois Relay Service 711).
- If you were allowed to return to regular Medicaid and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new provider, a surgery, blood test or x-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Fraud and Abuse

Molina Healthcare seeks to uphold the highest ethical standards for the provision of health care benefits and services to its members and supports the efforts of federal and state authorities to prevent fraud and abuse. Molina Healthcare investigates all suspected cases of fraud and abuse and promptly reports all confirmed incidents to the appropriate government agencies.

Here are a few examples of health care fraud and abuse:

- Your provider prescribes more services than are necessary, such as:
  - Appointments
  - Treatments
  - Prescriptions
- You are billed for services that you did not receive.
- Another person uses your member ID card.
- Another person sells your prescription drugs.
- Changing the information on a prescription.

You have the right to report your concerns to Molina Healthcare and/or the Illinois Department of Healthcare and Family Services. When reporting suspected incidences, please leave a detailed message including the names and phone numbers of the parties involved. You do not have to leave your name if you do not wish to do so.

Molina Healthcare of Illinois
Confidential Compliance Hotline: (866) 606-3889
Email: MHILCompliance@MolinaHealthcare.com
Online: https://molinahealthcare.Alertline.com

Molina Healthcare of Illinois
Attn: Compliance Officer
1520 Kensington Road, Suite 212
Oak Brook, IL 60523

Advance Directives

Using advance directives to state your wishes about your medical care

Many people today worry about the medical care they would get if they became too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.
This section explains your rights under Illinois law to accept or refuse medical care. It will help you choose your own medical care. This section also explains how you can state your wishes about the care you would want if you could not choose for yourself. This section does not contain legal advice, but will help you understand your rights under the law.

For legal advice, you may want to talk to a lawyer. For information about free legal services, call the Illinois State Bar Association at (800) 252-8908, Monday through Friday, 8:30 a.m. to 4:30 p.m.

Your right to choose your medical care

You have the right to make decisions about the health care you get now and in the future. You can state your medical care wishes in writing while you are healthy and able to choose. An advance directive is a written statement about how you want medical decisions made when you can no longer make them. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. It also must ask you if you have put your wishes in writing.

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 may decide you want to talk with a lawyer.

No one can make you complete an advance directive. You decide if you want to have an advance directive.
Talk to your health care provider to get an advance directive form. You may also call Member Services if you have any questions about how to get one of the forms. A lawyer could also help you.

What kinds of advance directives are there?

Under Illinois law, there are four types of advance directives you can use. You can fill out a form to complete an advance directive. You can use a Living Will, a Mental Health Treatment Preference Declaration, a Health Care Power of Attorney or a Do Not Resuscitate (DNR) Order.

What if I'm too sick to decide? What if I can't make my wishes known?

Most people can make their wishes about their medical care known to their providers, but some people become too sick to tell their providers about the type of care they want. Under Illinois law, you have the right to fill out a form while you're able to act for yourself. The form tells your providers what you want done if you can't make your wishes known.

If I don't have an advance directive, who chooses my medical care when I can't?

If you do not have an advance directive, Illinois law allows your next-of-kin to choose your medical care if you are expected to die and can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also (see below).

Living Will

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- In a coma that is not expected to end, or
- Beyond medical help, with no hope of getting better and can't make your wishes known, or
- Expected to die and can't make your wishes known.

You can choose what you would want if you were too sick to make your wishes known. You can state when you would or would not want food and water supplied artificially. The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

Do-Not-Resuscitate Order

You may also ask your doctor about a do-not-resuscitate order (DNR order). A DNR order means that cardiopulmonary resuscitation (CPR) will not be started if your heart stops. You and your doctor may decide together that your doctor should write a DNR order into your medical chart. If you have an accident, such as choking on food, the DNR order still allows health care workers to give you the Heimlich maneuver or take other appropriate action.

Health Care Power of Attorney

A Health Care Power of Attorney lets you choose someone to make health care decisions for you if you cannot. Is it is different from other types of powers of attorney. You can use a standard form or write your own health care power of attorney. You may give the person you choose specific directions about the health care you do or do not want. The person you choose must follow your wishes. The person you choose cannot be your doctor or other health care provider. You should have someone else witness your power of attorney. You can cancel your power of attorney by telling someone or by canceling it in writing. If you want to change your power of attorney, you must do so in writing.

What is the difference between a Durable Power of Attorney for medical care and a Living Will?

Your Living Will states the type of medical care you want if you can't make your wishes known. A Living Will only states your wishes about the use of life-support methods.

Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself. A Health Care Power of Attorney does not supersede a Living Will.

Mental Health Treatment Preference Declaration

A Mental Health Treatment Preference Declaration gives more specific attention to mental health care. The declaration can set forth certain wishes regarding treatment. You can write your wishes or choose someone to make your mental health decisions for you. In the declaration, you may choose someone to make decisions about mental health treatment if you are incapable. The person can indicate medication and treatment preferences, and preferences concerning admission or retention in a facility. The person must do what you say in your declaration unless a court orders differently or an emergency threatens your life or health.

Other Matters to Think About

You should talk to your family, your physician, or any agent or attorney-in-fact that you appoint about your decision to make an advance directive. If they know what health care you want, they will find it easier to follow your wishes. If you change your mind and cancel your advance directive, tell your family, your doctor, or any agent or person you appoint in your advance directive. No facility, doctor, or insurer can make you execute an advance directive. It is entirely your decision. If a facility, doctor, or insurer objects to following your advance directive, he or she must tell you and offer you help in finding alternative care.

After you complete an advance directive, give copies to your provider and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or

friends about what you have done. Don't just put these forms away and forget about them.

Organ and Tissue Donation

You can choose whether you would like your organs and tissues to be donated to others in the event of your death. By making your choice known, you can ensure that your wishes will be carried out immediately. Your families and loved ones will not have the burden of making this decision at an already difficult time.

Some examples of organs and tissues that can be donated are:

- Heart
- Lungs
- Liver
- Kidneys
- Pancreas
- Skin
- Bone
- Ligaments
- Veins
- Eyes

There are two ways to register to become an organ and tissue donor:

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Illinois Driver License or State ID Card, or
2. You can complete the Donor Registry Enrollment Form that is attached to the Illinois Living Will Form, and return it to the Illinois Department of Motor Vehicles

Definitions

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program or in reimbursement for services that are not or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Advance Directives – Written instructions relating to the provision of health care when an adult is incapacitated, such as a Living Will, a Durable Power of Attorney for Medical Care, a Declaration for Mental Health Treatment, or a Do Not Resuscitate Order.

Appeal – A formal request for Molina Healthcare to review a decision or action.

Authorization – An approval for a service.

Case manager – A Molina Healthcare employee who works with the member and providers to create a care plan based on the member's health needs and ensures the members receives all necessary services.

Care plan – An individualized member-centered, goal-orientated, written plan of care that assures the members receives all needed health care, medical, medically-related, behavioral and covered services in a timely manner.

Covered Services – Services and supplies covered by Molina Healthcare.

Emergency Medical Condition – A medical problem that you think is so serious that it must be treated right away by a provider.

Emergency Services – Services provided by a qualified provider that are needed to evaluate, treat, or stabilize an emergency medical condition.

Fraud – Intentional deception or misrepresentation by a person with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person.

Grievance – A complaint about Molina Healthcare or a health care provider.

Medical Home – Having one provider who will help you with most of your medical needs.

Member – A person who is eligible for Medicaid and who is enrolled in the Molina Healthcare plan.

Molina Healthcare – A Managed Care Organization licensed by the State of Illinois to provide prepaid medical and hospital services to Medicaid eligible consumers.

Participating/Contracted Provider – A provider who has entered into a contract with Molina Healthcare to provide covered services to members.

Post-Stabilization – Medicaid-covered services that you receive after emergency medical care.

Preventive Health Care – Health care focused on early detection and treatment of health problems and the prevention of disease or illness.

Primary Care Provider (PCP) - A Molina Healthcare contracted provider that you have chosen to be your personal provider. Your PCP helps you with most of your medical needs.

Prior Authorization – The process for any service that needs an authorization from Molina Healthcare before it can take place.

Provider Directory – A list of all of the network providers contracted with Molina Healthcare. Access our provider directory online at www.MolinaHealthcare.com.

Referral – A request from a PCP for his or her patient to see another provider for care.

Service Area – The geographic area where Molina Healthcare provides services.

Services – Services necessary for the diagnosis or treatment of disease, illness, or injury, without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort.

Specialist – A provider who focuses on a particular kind of health care.

Women's Health Care Provider (WHCP) – A doctor, nurse practitioner or provider whose specialty is obstetrics, gynecology or family practice. WHCP services are typically opted for by a female member as and when needed.

How to Pick a PCP Checklist

A Primary Care Provider (PCP) is the health care provider who will help you with most of your medical needs. Your PCP will give you care, offer advice, and refer you to a specialist when necessary. It is important that you find a PCP who meets your needs.

The following checklist will help you when you are picking a PCP.

- ☐ Look in Molina Healthcare's Provider Directory to find a list of contracted PCPs. Access the Provider Directory online at www.MolinaHealthcare.com. If you need help, call Molina Healthcare Member Services at (855) 766-5462, TTY/Illinois Relay Service 711.

- ☐ Is the PCP's office located in an area that is convenient for you?

- ☐ Does the PCP have office hours that are convenient for you and your family? This is especially important if you have family members who work or attend school.

- ☐ Your PCP's gender may be important to you. Would you prefer to see a male or female PCP?

- ☐ Do you or your family members speak a language other than English? Check to see if there is a PCP available who speaks your language.

Picking a PCP is important. When you find a good PCP, you can develop a lasting relationship that will ensure a health care partnership for years to come.

First Visit Checklist

Now that you have picked a PCP, be sure to schedule a checkup soon, even if you're not sick. During the appointment, you will have a chance to get to know your PCP and to ask a number of questions that will help you develop a good relationship.

Here are some things you should do to get ready for your first appointment:

- ☐ Make a list of the medications that you are currently taking.
- ☐ Make a list of any allergies that you have.
- ☐ If you have not been feeling well, make a list of your symptoms and take it to your appointment.
- ☐ Make a list of anything you would like to discuss with your PCP.
- ☐ Allow time to arrive at your appointment a few minutes early so that you have time to check in at the reception desk.
- ☐ Remember to take your Molina ID card with you to your appointment.

During the appointment, be sure to ask your PCP:

- ☐ How long should I expect to wait for a regular appointment?
- ☐ Can I be seen on the same day if the need is urgent?
- ☐ Who should I call if I have problems after hours? Remember, Molina's Nurse Advice Line is open 24 hours a day, 7 days a week to answer your health care questions when your PCP is not available.
- ☐ What should I do if I need to see a specialist?
- ☐ What should I do if I have to cancel an appointment?
- ☐ What if I think of a question after I leave the office?
- ☐ When do I need to return for another visit?

Date: _____

Time: _____

Notes: _____

_____

_____

Molina Healthcare

Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach copies of any records you wish to submit. (Do Not Send Originals)
3. If you have someone else submit on your behalf, you must give your consent below.
4. You may submit the completed form through one of the following ways:
    a. Send to the address listed below,
    b. Fax to the fax number below, or
    c. Present your information in person. To do this, call us at the number listed below.
5. We will send a written acknowledgement letter of your request. It will be mailed to you within three (3) working days after the request is received.

Member's name: _____Today's date: _____

Name of person requesting grievance/appeal, if other than the Member: _____

Relationship to the Member: _____

Member's ID #: _____

Daytime telephone #: _____

Specific issue(s): _____

_____

_____

(Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed)

By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature: _____Date: _____

If you would like help with your request, we can help. We can help you in the language you speak or if you need other special support for hearing or seeing. You can call, write or fax us at:

Molina Healthcare of Illinois
Attn: Grievance & Appeal Dept.
1520 Kensington Dr., Suite 212
Oak Brook, IL 60523

Member Services: (855) 766-5462
Fax Number: (630) 571-1220

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P.O. Box 4004
Bothell, WA 98041-4004