MOLINA® HEALTHCARE
Your Extended Family.

IMPORTANT INFORMATION

Member Handbook Insert
Effective Jan. 1, 2018

Grievances and Appeals (Pages 59-62)
Effective January 1, 2018, there will be changes to the way you appeal a decision Molina Healthcare made and the way you ask for a state hearing. There are also changes in the amount of time you can report a complaint, also known as a grievance, to the plan. The changes are below.

Topic	Before January 1, 2018	January 1, 2018 and after
How long do you have to appeal a decision we made?	90 calendar days	**60 calendar days**
When will you receive a state hearing form?	You receive a hearing form at the time Molina Healthcare makes a decision on your request for a service.	**You will only receive a state hearing form if Molina Healthcare does not change their decision as part of your appeal.**
When can you request a state hearing?	Hearings must be requested within 90 days of the date on the state hearing form sent by Molina Healthcare.	**You must first follow Molina Healthcare's appeal process before you can request a state hearing. If you have an unfavorable appeal, you will also receive a state hearing form. You have 120 days from the mailing date of the form to request a hearing.**
When can I report a complaint (also known as a grievance) to Molina Healthcare?	You have 90 days from the date you identify the issue causing the dissatisfaction to report the grievance to the Molina Healthcare.	**You can file a grievance at any time.**

Services Covered by Molina Healthcare (page 29)
As a Molina Healthcare member, you will continue to receive all medically-necessary Medicaid covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

Healthchek (page 39)
If you have questions or need help scheduling Healthchek services, call Member Services. We can also help you get a referral for Women, Infants, and Children (WIC), Help Me Grow, Bureau for Children with Medical Handicaps (BCMH), Headstart, and community services such as food, heating assistance and other utilities.

Just Cause Membership Termination (page 63)
You can ask for just cause termination at any time if you move and your current MCP is not available where you now live and you must receive non-emergency medical care in your new area before your MCP membership ends. If your membership ends for this or any other Just Cause reason and you live a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently.

MHO-2227
94559200H0118

Things to Keep in Mind if you End Your Membership (page 64)

If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker. 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.

Excluded from MCP Membership (page 64)

If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Plan. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Plan.

Questions?

To view your Member Handbook or learn more about your covered benefits and services, visit our website at www.MolinaHealthcare.com/OHMedicaidHandbook. If you have questions, call Member Services at (800) 642-4168 or for hearing impaired TTY/Ohio Relay (800) 750-0750 or 711. We're ready to help from 7 a.m. to 7 p.m., Monday through Friday.