Certificate of coverage

This Certificate of Coverage is issued by Molina Healthcare of Illinois, Incorporated, an Illinois corporation, operating as a health maintenance organization, hereinafter referred to as "Molina Healthcare." This Certificate of Coverage represents that in consideration of the Member's enrollment, Molina Healthcare shall provide and/or arrange for covered health care services to the Member in accordance with the provisions of the Molina Healthcare HealthChoice Illinois Member Handbook.

This Member Handbook should be read thoroughly. Many of the provisions of the Member Handbook are interrelated; therefore, reading just one or two items may not give a clear understanding to the reader. The provisions in the Member Handbook include, but are not limited to information on:

- Primary Care Providers
- Women's Health Care Providers
- Member Services
- Covered Services
- Non-Covered Services
- Emergency Care
- Care When Outside the Service Area
- Specialty Care
- Complaints, Grievances and Appeals

Many words used in this Member Handbook have special meanings. Such words will be capitalized, and will be defined for you. By using these definitions, the clearest understanding will be obtained.

The Molina Healthcare HealthChoice Illinois Handbook may be subject to amendment, modification, or termination by mutual agreement between Molina Healthcare and the Illinois Department of Healthcare and Family Services without the consent of any Member. Members will be notified of such changes as soon as possible after they are made. By choosing health care coverage under Molina Healthcare, Members agree to all the terms and conditions in the Member Handbook.

IN WITNESS WHEREOF, Molina Healthcare has caused this Certificate of Coverage to be executed by its duly authorized officer on the date indicated below, under which Certificate coverage will begin on the Effective Date indicated on the Member's Molina Healthcare identification card.

September 26, 2023

Matt Wolf
Molina Healthcare of Illinois, Inc. Plan President

Date

Description of coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan
- How specialists (both in and out of network) can be accessed
- How to file complaints and appeal health care plan decisions (including external independent reviews)
- How to obtain information about your health care plan, including general information about its financial arrangements with providers

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. Because the Description of Coverage is not a legal document, for full benefit information, please refer to your Member Handbook or contact Molina Healthcare at the toll-free number on the next page. In the event of any inconsistency between your Description of Coverage and the Member Handbook, the Description of Coverage will control.

For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at (877) 527-9431. Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.

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

(Source: Amended at 34 Ill. Reg. 6879, effective April 29, 2010)

Description of coverage worksheet

Health plan: Molina Healthcare of Illinois
Program name: HealthChoice Illinois
Address: 2001 Butterfield Rd., Suite 750
Downers Grove, IL 60515

Toll-free phone number: (855) 687-7861

		Description of Coverage
Basics	Your Doctor	Selection of primary care physician should occur at the time of enrollment. Women may also select a women's health care provider (WHCP). Changes may be made by calling Member Services.
	Annual Deductible	None
	Out-of-Pocket	None
	Lifetime Maximums	None
	Pre-existing Condition Limitations	None

		Description of Coverage	Health Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care	All	100%	0%
	Room & Board	All	100%	0%
	Surgeon's Fee	All	100%	0%
	Doctor Visits	All	100%	0%
	Other Miscellaneous Charges	Medically necessary and eligible services including laboratory, radiology and supplies provided by the hospital.	100%	0%
	Hospital Services *Outpatient*	Covered	100%	0%
	Inpatient	Covered	100%	0%
Emergency Care	Emergency Services	Medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Emergency Care (continued)	Emergency Post-stabilization Services	Services provided to a Member that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.	100%	0%
	Emergency dental services	Covered	100%	0%
In the Doctor's Office	Doctor's Office Visits	Primary care and specialist	100%	0%
	Routine Physical Exams	Covered	100%	0%
	Diagnostic Tests and X-rays	Covered	100%	0%
	Immunizations	Covered	100%	0%
	Allergy Treatment and Testing	Covered	100%	0%
	Wellness Care	Covered	100%	0%
	Yearly well-adult exams	Covered	100%	0%
Medical Services	Abortion	Abortion services are covered by Medicaid (not your MCO) by using your HFS medical card.	Not applicable	Not applicable
	Outpatient Surgery	Covered	100%	0%
	Maternity Care *Hospital Care* *Physician Care*	Covered	100%	0%
		Covered	100%	0%
	Infertility Services	Not Covered		
	Mental Health *Outpatient* *Inpatient*	Covered	100%	0%
		Covered	100%	
	Substance Abuse *Outpatient* *Inpatient*	Covered	100%	0%
		Covered	100%	0%
	Outpatient Rehabilitation Services	Covered	100%	0%
	Advanced Practice Nurse services	Covered	100%	0%
	Ambulatory surgery	Covered	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Medical Services (continued)	Chiropractic services	Covered Limited to Members 20 years of age and younger for the treatment of spine by manual manipulation. Not covered for Members 21 and older.	100%	0%
	EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services	Covered	100%	0%
	Family planning services and supplies	Covered Covered benefits include: Yearly exam for females 12 to 55 years of age, which includes a breast exam, pelvic exam and pap smear. Pregnancy testing. Contraceptive-related services such as the insertion of intrauterine devices (IUDs) and the implantable contraceptive; permanent methods of birth control, including tubal ligation, trans-cervical contraception and vasectomy	100%	0%
	Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	Covered	100%	0%
	Nursing facility services	Covered	100%	0%
	Podiatry (foot) services	Covered	100%	0%
	Preventive mammogram (breast) and cervical cancer (pap smear) exams.	Covered Women may self-refer	100%	0%
	Renal dialysis (kidney disease)	Covered	100%	0%
	Specialist services	Covered	100%	0%
	Speech therapy services	Covered	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Long Term Service and Supports (Waiver Services)	**Persons with Disabilities or Persons with HIV/ AIDS waiver** • Adult Day services, • Adult Day service Transportation, • Environmental Accessibility Adaptations Home, • Home Health Aide, • Nursing Intermittent, Skilled Nursing (RN and LPN), • Occupational Therapy, • Physical Therapy, • Homemaker, • Home Delivered Meals, • Personal Assistant, • Personal Emergency Response System (PERS), • Respite, • Specialized Medical Equipment and Supplies	Covered	100%	0%
	Traumatic Brain Injury Waiver • Adult Day service, • Adult Day service Transportation, • Environmental Accessibility Adaptions Home, • Supported Employment, • Home Health Aide, • Nursing Intermittent, Skilled Nursing, • Occupational Therapy,	Covered	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Long Term Service and Supports (Waiver Services) (continued)	**Traumatic Brain Injury Waiver (continued)** • Physical Therapy, • Speech Therapy, • Prevocational Services, • Habilitation - Day, • Homemaker, • Home Delivered Meals, • Personal Assistant, • Personal Emergency Response System (PERS), • Respite, • Specialized Medical Equipment and Supplies, • Behavioral Services	Covered	100%	0%
	Persons Who Are Elderly Waiver • Adult Day service, • Adult Day service Transportation, • Homemaker, • Personal Emergency Response System (PERS)	Covered	100%	0%
	Supportive Living Facility Waiver • Nursing Services • Personal Care • Medication administration, oversight and assistance • in self-administration • Laundry • Housekeeping • Maintenance • Social and recreational programming	Covered	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Long Term Service and Supports (Waiver Services) (continued)	**Supportive Living Facility Waiver** • Ancillary services • Twenty-four- • (24)-hour response/security staff • Health promotion and exercise • Emergency call system • Daily checks • Quality Assurance plan • Management of resident funds, if applicable	Covered	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Other Services	Durable Medical Equipment (DME)	Covered	100%	0%
	Medical supplies	Covered	100%	0%
	Respiratory equipment and supplies	Covered	100%	0%
	Hospice	Covered	100%	0%
	Home Health Care	Covered	100%	0%
	Prescription Drugs, including certain prescribed over-the-counter drugs	Covered	100%	0%
	Dental Services including oral surgeons (20 years of age or younger)	Covered benefit. Dental services, including oral surgery, X-rays, sealants, fillings, crowns (caps), root canals, dentures and extractions (pulling). Cleanings (1 every 6 months) Dental exams (1 every 6 months) Some limitations apply	100%	0%

		Description of Coverage	Health Plan Covers	You Pay
Other Services (continued)	Dental Services (21 years of age and older)	Dental services, including oral surgery, X-rays, fillings, crowns (caps), root canals, extractions (pulling), dentures and denture repairs. Pregnant women can get extra services. The services include exams, cleanings and deep cleanings. As an additional benefit, Members 21 years of age and older get: Cleanings (1 every 6 months) Dental Exam (1 every 6 months) Some limitations apply	100%	0%
	Vision Care (optical and optometrist) services, including eyeglasses	One exam per year for all Members one pair of eyeglasses (lenses and frames) in a two-year period for all Members No restrictions on replacement glasses for Members 0 and 20 years of age Members 21 years of age and older are limited to replacement lenses when medically necessary As an additional benefit, Molina Healthcare provides a $40 credit to use toward your eyeglasses benefit (lenses and frames) per year, when choosing outside of the approved frame options	100%	0%
	Hearing (audiology) services, including hearing aids	Covered	100%	0%
	Speech therapy services	Covered	100%	0%
	Transportation to covered services	Covered	100%	0%
	Practice Visits	Covered benefits for enrollees with Special Needs	100%	0%

Service Area
Molina Healthcare of Illinois offers Medicaid services in counties across Illinois. Molina will be serving all counties in Illinois beginning April 1, 2018.

Exclusions and limitations

Limited covered services
- The health plan may provide sterilization services only as allowed by State and federal law.
- If the health plan provides a hysterectomy, the health plan shall complete HFS Form 1977 and file the completed form in the Member medical record.

Non-covered services
Some services are excluded from this plan. The following are some excluded services. For more information visit our website at MolinaHealthcare.com or call Molina Healthcare Member Services at **(855) 687-7861**.

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

- Services that are experimental or investigational in nature
- Services that are provided by a non-network provider and not authorized by your Health Plan
- Services that are provided without a required referral or required prior authorization
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies
- Early Intervention Services, including Care Management
- Services funded through the Juvenile Rehabilitation Services Matching Fund
- Services such as assisted suicide
- Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy)

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 at (855) 687-7861, Monday through Friday 8 a.m. to 5 p.m., or visit MolinaHealthcare.com.

Pre-certification and utilization review
For non-emergency care, the Member's primary care provider (PCP) must participate in and concur with inpatient hospital stays by pre-approving elective admissions, outpatient surgery and specialty services. In addition to the PCP's pre-approval of elective admissions, hospital admissions require the authorization of the health plan's Medical Director or designated Utilization Management (UM) department representative. The PCP or specialist must make the necessary arrangements for hospitalization, outpatient procedures or other services if medically necessary as defined in the certificate of coverage.

Emergency care
In an emergency, a Member immediately should seek medical care by calling 9-1-1 or going to the nearest hospital emergency department. Medically necessary emergency services are covered regardless of whether or not the emergency services are provided by a participating provider. Medically necessary post-stabilization medical services provided by a non-participating provider are covered if either pre-approved by Molina Healthcare or if Molina Healthcare does not deny approval for such post-stabilization medical services within one hour of the non-participating provider's good faith attempt to obtain approval for such services from Molina Healthcare.

Primary care physician selection
Members must choose a primary care provider (PCP) from the provider directory available at the time of enrollment. The Member's PCP is the Member's medical home responsible for providing and coordinating care, making recommendations for specialty care and other services. Members may change this PCP by visiting MyMolina.com to make the change online or by calling Molina Healthcare Member Services at **(855) 687-7861**.

Access to specialty care
A PCP may recommend a participating specialist provider to a Member for medically necessary covered services. A Member may see a participating specialist provider for medically necessary covered services if the specialist obtains approval from Molina Healthcare first. In some situations, a participating specialist may request a standing authorization.

If Molina Healthcare determines a request for authorization from a specialist is appropriate for medically necessary services, and a qualified specialist who is a participating provider does not exist, Molina Healthcare may approve an authorization to a specialist who is not a participating provider; however, the specialist must be an Illinois Medical Assistance Program Provider.

Female Members may see, in addition to a PCP, a family practitioner, obstetrician/gynecologist, or women's health care provider (WHCP) without a referral for all covered services. At the request of any WHCP Molina Healthcare shall follow health plan's utilization and quality assurance procedures and protocols in evaluating the WHCP as a PCP.

Members do not need a prior approval to access some covered services if the provider participates in Molina Healthcare's network. This includes emergency services, behavioral health, vision and dental care. Additionally, Members may obtain family planning services from out-of-network providers.

Out-of-area coverage
Out-of-area coverage is available only for emergency care. Once the condition has been stabilized, the Member must return to the service area as soon as medically appropriate to receive continuing and/or follow-up covered services.

Financial responsibility
The Member does not have any co-payments, deductibles or premiums for covered, eligible health care services or for prescriptions or durable medical equipment dispensed from an in-network pharmacy or provider.

Continuity of treatment
Subject to certain conditions, a new Member, who either requires an ongoing course of treatment, who is in her second (2nd) or third (3rd) trimester of pregnancy, or who is receiving postpartum care directly related to the delivery after pregnancy, may request to continue to see their existing provider even if this provider is not contracted with Molina Healthcare for a brief time after the effective date of coverage.

If an existing Member's participating provider leaves the Molina Healthcare network, the health plan will notify the Member that the provider is leaving the Molina Healthcare network. Subject to certain conditions, if an existing Member's participating provider leaves the Molina Healthcare network and the existing Member is either receiving an ongoing course of treatment from the participating provider, or the existing Member is in her second or third trimester of pregnancy and is receiving care from the participating provider, the existing Member may request to continue to see that provider for a brief time after the Member is notified of the provider leaving the network.

In order for services rendered to a Member by a provider to be covered by Molina Healthcare, the provider must agree to Molina Healthcare's Quality Improvement and Utilization Plan policies and procedures, and payment. If services requested are denied and the Member would like to appeal, the Member must make their request within sixty (60) days of being notified of the denial. Molina Healthcare will respond in writing fifteen (15) business days of receiving all required information with approval or the specific reason for denial of the request.

Grievance & appeals:

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

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item.

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

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

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

- Your provider or 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 an Molina Healthcare staff member was rude to you.
- Your provider or an 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) 687-7861. You can also file your grievance in writing via mail or fax at:

Molina Healthcare
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax: (855) 502-5128

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

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

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

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

Appeals

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

You may not agree with a decision or an action made by Molina Healthcare about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Adverse Benefit Determination form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Adverse Benefit Determination form. The list below includes examples of when you might want to file an appeal.

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

Here are two ways to file an appeal.

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

Molina Healthcare
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax: (855) 502-5128

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

Can someone help you with the appeal process?

You have several options for assistance. You may:

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

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

Appeal process

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

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

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

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

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

Things to keep in mind during the appeal process:

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

How can you expedite your appeal?

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

How can you withdraw an appeal?

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

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

What happens next?

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

State fair hearing

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

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

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

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

  Illinois Department of Healthcare and Family Services
  Bureau of Administrative Hearings
  69 W. Washington Street, 4th Floor
  Chicago, IL 60602
  Fax: (312) 793-2005
  Email: HFS.FairHearings@illinois.gov
  Or you may call (855) 418-4421, TTY: (800) 526-5812

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

  Illinois Department of Human Services

  Bureau of Hearings

  69 W. Washington Street, 4th Floor

  Chicago, IL 60602

  Fax: (312) 793-8573

  Email: DHS.HSPAppeals@illinois.gov

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

State fair hearing process

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

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

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

Continuance or postponement

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

Failure to appear at the hearing

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

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

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

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

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

The state fair hearing decision

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

External review (for medical services only)

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

- Board certified provider with the same or like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your identity during the review

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

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

Molina Healthcare of Illinois
Attn: Appeals & Grievances
PO Box 182273
Chattanooga, TN 37422
Fax: (855) 502-5128

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) 687-7861. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

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

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will 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.