Certificate of Coverage
Illinois Medicaid HealthChoice Plan

Meridian Health Plan of Illinois, Inc.

How to Use Your Certificate

This Certificate should be read thoroughly. Many of the provisions of this Certificate are interrelated; therefore, reading just one or two items may not give a clear understanding to the reader.

Many words used in this Certificate have special meanings. Such words will be capitalized and are defined in Section I. By using these definitions, the clearest understanding will be obtained.

This Certificate may be subject to amendment, modification, or termination by mutual agreement between Meridian Health Plan of Illinois, Inc. ("Health Plan") and the Illinois Department of Healthcare and Family Services (HFS) without the consent of any Member. Members will be notified of such changes as soon as possible after they are made. By choosing healthcare coverage under Health Plan, Members agree to all the terms and conditions in this Certificate.

Description of Coverage – Cover Page

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

- What emergency room visits will be paid for by your healthcare plan
- How specialists (both in and out of network) can be accessed
- How to file complaints and appeal healthcare plan decisions (including external independent reviews)
- How to obtain information about your healthcare 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. Since the Description of Coverage is not a legal document, for full benefit information please refer to your contract or certificate, or contact your healthcare plan at the toll-free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Healthcare and Family Services at 800-226-0768. Please be aware that the Illinois Department of Healthcare and Family Services will not be able to provide specific plan information. For this type of information you should contact Health Plan directly.

Description of Coverage Worksheet

Plan Name: Meridian Health Plan
Address: 300 S. Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700
Fax: 312-980-0404

Category	Services	Description of Coverage
Basics	Your Doctor	Members must select a PCP at the time of enrollment. This choice may be changed by calling Member Services at 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711. Female Members may receive services from any in-network Woman's Primary Health Care Provider (WHCP) without a referral from her PCP.
		Members may choose to have a PCP that is a NCQA certified Patient-Centered Medical Home (PCMH) provider. American Indian Members may receive services from an Indian Health Care Provider in and outside of the State of Illinois.
	Annual Deductible	None
	Out-of-Pocket Maximum	None. Health Plan does not charge any co-pays for covered services.
	Lifetime Maximum	None
	Preexisting Condition Limitations	None

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care	All	100%	$0
	Room and Board	All	100%	$0
	Surgeon's Fees	All	100%	$0
	Doctor's Visits	All	100%	$0
	Medications	State of Illinois Drug Product Selection Program (Formulary)	100%	$0
	Other Miscellaneous Charges	Medically necessary and eligible services including laboratory, radiology and supplies provided by the hospital.	100%	$0
Emergency Care	Emergency Services	Medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in 1) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 2) serious impairment in bodily functions; or 3) serious dysfunction of any bodily organ or part.	100%	$0
	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
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
Medical	Outpatient Surgery	Covered	100%	$0

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
Services	Maternity Care Hospital Care Physician Care	 Covered Covered	 100% 100%	 $0 $0
	Infertility Services	Not covered		
	Mental Health Outpatient Inpatient	 Covered Covered	 100% 100%	 $0 $0
	Substance Abuse Outpatient Inpatient	 Covered Covered	 100% 100%	 $0 $0
	Outpatient Rehabilitative Services	Covered	100%	$0
Other Services	Hospice	Covered	100%	$0
	Home Health Care	Covered	100%	$0
	Prescription Drugs	When prescribed or authorized by the Primary Care Provider (PCP), selected prescription drugs, devices or supplies are a benefit. The drug must be approved by the Health Plan and listed in the Health Plan formulary or have prior authorization.	100%	$0
	Dental Services	Covered	100%	$0
	Vision Care	Optical services and supplies and optometrist services are covered. Adult eyeglasses limited to once every two years.		
	Medical Transportation	Covered	100%	$0
	Skilled Nursing	Covered	100%	$0
	Durable Medical Equipment	Covered, rental or purchase as per the Health Plan's decision.	100%	$0
	Podiatry Services	Covered		
HCBS Waiver Services	Aging Waiver Services**	• Adult Day Care • Transportation to Adult Day Care Center • Homemaker Services • Personal Emergency Response System	100%	$0
	Individuals with Disabilities	• Adult Day Care • Transportation to Adult Day Care Center		

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
	Waiver**	• Personal Emergency Response System • Home Modifications • Home Delivered Meals • Home Health Aide • Homemaker Services • Occupational Therapy • Personal Assistant • Physical Therapy • Respite • Skilled Nursing • Intermittent Nursing • Specialized Medical Equipment and Supplies • Speech Therapy	100%	$0
	HIV/AIDS Waiver**	• Adult Day Care • Transportation to Adult Day Care Center • Personal Emergency Response System • Home Modifications • Homemaker Services • Home Delivered Meals • Personal Assistant • Physical Therapy • Occupational Therapy • Respite • Skilled Nursing • Home Health Aide • Speech Therapy • Specialized Medical Equipment and Supplies • Intermittent Nursing	100%	$0
	Individuals with Brain Injury Waiver**	• Adult Day Care • Transportation to Adult Day Care Center • Behavioral Services • Day Habilitation • Personal Emergency Response System • Home Modifications • Home Delivered Meals • Homemaker Services • Occupational Therapy • Personal Assistant • Prevocational Services • Respite • Intermittent Nursing • Skilled Nursing • Home Health Aide • Specialized Medical Equipment and Supplies • Speech Therapy • Supported Employment Services • Physical Therapy	100%	$0
	Supported Living Facilities Waiver**	• Nursing Services • Personal Care • Medication Assistance • Laundry • Housekeeping • Maintenance	100%	$0

Category	Services	Description of Coverage	Health Care Plan Covers	You Pay
		• Social and Recreational Programming • Daily checks • Ancillary services • 24 hour response/security staff • Health Promotion and exercise • Emergency call system • Quality Insurance Plan • Management of Resident Funds, if applicable		
	Children who are Medically Fragile/Technology-Dependent Waiver	• Home Modifications • Placement Maintenance Counseling • Respite • Nurse Training • Family Training	100%	$0

** Use your HFS Medical Card to obtain these services. They are not covered by Health Plan.*
***HCBS Waiver Services only covered if Member determined eligible by appropriate State Agency. Health Plan does not determine eligibility for HCBS Waiver Services.*

Service Area
Counties of Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, Cumberland, DeKalb, DeWitt, Douglas, Dupage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McHenry, McLean, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago, and Woodford.

Exclusions and Limitations
- Elective cosmetic surgery and infertility services except as allowed by State law
- Non-emergent services and supplies not authorized by the PCP, if authorization is required
- Non-emergency dental services for Members over the age of 21 (except as otherwise provided in this Certificate)
- Services not medically necessary or considered experimental, investigational and/or educational
- Work-related injuries, illnesses or immunizations required for employment
- Services provided in a State Facility operated as a psychiatric hospital as a result of forensic commitment
- Services provided through a Local Education Agency (LEA)
- Services provided by a non-participating provider and not authorized by Health Plan, unless otherwise provided in this Certificate
- Services provided without a required referral or prior authorization as set forth in the Provider Manual
- Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and an HFS form 2189 must be completed and filed in the Member's medical record
- If a hysterectomy is provided, an HFS Form 1977 must be completed and filed in the Member's medical record

Pre-Certification and Utilization Review
For non-emergency care, the Member's PCP participates in and concurs with all inpatient hospital stays by pre-approving all elective admissions, outpatient surgery and specialty services. In addition to the PCP's pre-approval of all elective admissions, the Health Plan's Medical Director or designated Utilization Management ("UM") Department Representative must authorize all hospital admissions. The PCP or specialist by referral will 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 from the nearest hospital emergency department and notify the Health Plan within 24 hours of an emergency admission or within 24 hours of when the Member is able to notify the Health Plan. 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 participating or non-participating provider are covered within one hour of a request for authorization to the Health Plan from the treating provider and thereafter if either pre-approved by the Health Plan or if the Health Plan does not deny approval for such post-stabilization medical services within one hour of the provider's good faith attempt to obtain

approval for such services from the Health Plan. If a non-participating provider, post-stabilization services will be covered if the Health Plan and the non-participating provider are unable to reach an agreement concerning the Member's care, and a participating provider is either unavailable for a consultation, in which case the Health Plan must pay for services provided until a participating provider may be contacted and either concurs with the treating non-participating provider's plan of care or assumes responsibility for the Member's care.

Primary Care Provider (PCP) Selection
Members must choose a PCP from the provider directory available at time of enrollment. The Member's PCP is responsible for providing and coordinating care, approving referrals to specialists and other services. Members may change their PCP by calling Member Services at 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711.

Access to Specialty Care
A Member may see a specialist participating provider for medically necessary services, if the Member obtains a referral from his or her PCP. The PCP must approve services or additional referrals recommended by specialist participating providers. Members should contact their PCP to determine what referral arrangements exist. If a referral arrangement does not exist between a Member's PCP and the desired specialist, then the Member has the right to change his or her PCP by calling Member Services. In some situations, a Member may request a standing referral to a specialist who is a participating provider. Prior authorization by the Health Plan is not required for routine specialist office visits.

If a Member's PCP determines a referral to a specialist is appropriate for medically necessary services and a qualified specialist who is a participating provider does not exist, the PCP may approve a referral to a specialist who is not a participating provider; provided, however, that the specialist is an Illinois Medical Assistance Program Provider.

Female Members may choose, in addition to a PCP, a family practitioner or obstetrician/gynecologist who is also a participating provider as her Woman's Health Care Provider ("WHCP"). After this selection, a Member may see her designated WHCP without a referral for all covered services. At the request of any WHCP, the Health Plan shall follow its quality assurance procedures and protocols in evaluating the WHCP as a PCP.

Out-of-Area Coverage
Out-of-area coverage is only available for emergency and post-stabilization 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 care. The Member must contact the Health Plan within 24 hours of an emergency admission or within 24 hours of when the Member is able to notify the Health Plan if hospitalized for an emergency condition.

Financial Responsibility
There are no co-payments, deductibles or premiums payable by the Member for covered, eligible care. A Member may request a description of the financial relationships between the Health Plan and any healthcare provider, the percent of co-payments, deductibles and total premiums spent on health care and related administrative expenses, as well as a notice of the Member's right to request healthcare provider information from his or her provider as set forth in the Managed Care Reform and Patient Rights Act.

Continuity of Treatment
If a Member is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, the Health Plan shall assume responsibility for the management of such care and shall be liable for all claims for covered services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per diem basis, the Health Plan's liability shall begin on the effective date of enrollment. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, the Health Plan will have no liability for the hospital stay.

If a Member is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Certificate is terminated, the Health Plan shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. The Health Plan will maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per diem basis, the Health Plan shall be liable for payment for any medical care or treatment provided to a Member until the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, the Health Plan shall be liable for payment for any inpatient medical care or treatment provided to a Member where the discharge date is after the effective date of disenrollment.

The Health Plan will provide coordination of care assistance to Prospective Members to access a PCP or WHCP, or to continue a course of treatment, before the Health Plan's coverage becomes effective, if requested to do so by the Prospective Member, or if the Health Plan has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Member shall attempt to contact the Prospective Member no later than two business days after the Care Coordinator is notified of the request for coordination of care.

In the event that the physician of a new Member who is in an active, ongoing course of treatment or is in the third trimester of pregnancy is not a network provider, the Health Plan will permit such Member to continue an ongoing course of treatment with such physician for up to 90 days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patients' Rights Act, only if the out-of-network physician agrees to provide such ongoing course of treatment, and if such out-of-network physician agrees to: (i) accept reimbursement at the Health Plan's established rates based on a review of the level of services provided, (ii) adhere to the Health Plan's QA requirements, (iii) provide necessary medical information related to health care and (iv) adhere to the Health Plan's policies and procedures, including, but not limited to procedures regarding referrals.

The Health Plan will provide for transition of services in accordance with Section 25 of the Managed Care and Patient's Rights Act (215 ILCS 134/25).

Grievance and Appeal Process
We want you to be happy with services you get from Meridian Health Plan 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. If you need help filing a grievance call your Care Coordinator or Member Services at 866-606-3700.

Meridian Health Plan 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. Meridian has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

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

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

- Your provider or a Meridian Health Plan 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 Meridian Health Plan staff member was rude to you
- Your provider or a Meridian Health Plan 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 Meridian Health Plan at 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711. You can also file your grievance in writing via mail or fax at:

Meridian Health Plan
Attn: Grievance and Appeals Dept.
300 South Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700
TTY: 711
Fax: 833-669-1734

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 866-606-3700.

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 including a physician or an attorney. This person will be "your representative." If you decide to have someone represent you or act for you, inform Meridian 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 Meridian Health Plan 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 **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 **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 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711. 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:

Meridian Health Plan
300 South Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700
TTY: 711
Fax: 833-383-1503

For pharmacy services:

MeridianRx
1 Campus Martius, Suite 750
Detroit, MI 48226
Fax: 855-580-1695

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 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 **ilmeridian.com** or call us at 866-606-3700 to obtain the form.

Appeal Process
We will send you an acknowledgement letter within three 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.

Meridian Health Plan will send our decision in writing to you within 15 business days of the date we received your appeal request. Meridian Health Plan may request of you and the State of Illinois an extension up to 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 Meridian'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 Meridian Health Plan'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 at no cost to you
- You have the option to be there when Meridian reviews your appeal

How can you expedite your Appeal?
If you or your provider believes our standard timeframe of 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 24 hours if we need more information. Once all information is provided, we will call you within 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.

Meridian 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 Meridian Health Plan at 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711.

What happens next?
After you receive the Meridian Health Plan 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 **120 calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **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 Meridian Health Plan 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 https://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.govOr 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 http://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 business days before the hearing, you will receive information from Meridian Health Plan. 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 Meridian Health Plan and the Impartial Hearing Officer at least three 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 **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 35 days from the date of this letter. If you have questions, please call the Hearing Office.

External Review (for medical services only)
Within **30 calendar days** after the date on the Meridian appeal Decision Notice, you may choose to ask for a review by someone outside of Meridian Health Plan. 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:

Meridian Health Plan
Attn: Grievance and Appeals Dept.
300 South Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700
TTY: 711
Fax: 833-383-1503

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have five 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 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 Meridian Health Plan a letter with their decision within five calendar days of receiving all the information they need to complete their review.

Expedited External Review (for medical services only)
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 866-606-3700. 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.

Meridian Health Plan
Attn: Grievance and Appeals Dept.
300 South Riverside Plaza, Suite 500
Chicago, IL 60606
Phone: 866-606-3700
TTY: 711
Fax: 833-383-1503

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

IMPORTANT: In the event of any inconsistency between your Description of Coverage and Certificate of Coverage, the terms of the Certificate will control.

Meridian Health Plan of Illinois, Inc.
300 South Riverside Plaza, Suite 500
Chicago, IL 60606

CERTIFICATE OF COVERAGE

This Certificate is issued by Meridian Health Plan of Illinois, Inc., an Illinois Corporation operating as a health maintenance organization, hereinafter referred to as "Health Plan" to <Member First Name> <Member Last Name> hereinafter referred to as "Member". In consideration of Member's enrollment, the Health Plan shall provide and/or arrange for covered health services to Member in accordance with the provisions of this Certificate.

IN WITNESS WHEREOF, the Health Plan has caused this Certificate to be executed by its duly authorized officer on the date indicated below, under which Certificate coverage will commence on the effective date indicated below.

Effective Date:

<Effective Date>

Meridian Health Plan of Illinois, Inc.

By: <Signature Image>
President and CEO

Dated: <DATE>

Certificate of Coverage Table of Contents

MERIDIAN HEALTH PLAN OF ILLINOIS, INC

SECTION I. DEFINITIONS

A. **"Action"** means a (i) denial or limitation of authorization of a requested service; (ii) reduction, suspension, or termination of a previously authorized service; (iii) denial of payment for a service; (iv) failure to provide services in a timely manner; (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Contracting Area. (v) failure to respond to an appeal in a timely manner; and (vi) if Health Plan is the only managed care organization contracted with the Department serving a rural area, the denial of a Member's request to obtain services outside the approved Contracting Area.

B. **"Appeal"** means a request for review of a decision made by the Health Plan with respect to an Action.

C. **"Chronic"** means an illness or injury that is, or is expected to be of a long duration and/or frequently recurs and is always present to a greater or lesser degree. Chronic conditions may have acute episodes.

D. **"Contract"** means the agreement between Health Plan and the Department under which this coverage is made available to Eligible Persons.

E. **"Covered Services,"** as described more fully in Attachment A - Covered Services and Benefits, Limitations and Exclusions, are those benefits, services, and supplies which Meridian Health Plan of Illinois, Inc., ("Health Plan") has contracted with the Department to arrange for Members.

F. **"Department"** shall mean the Illinois Department of Healthcare and Family Services.

G. **"Dependent"** shall mean an individual meeting the requirements under the Medical Assistance Program who is a Member of a medical assistance case and an Eligible Person.

H. **"Effective Date"** shall mean the date on which a Member's coverage becomes effective.

I. **"Eligible Person"** shall mean any person covered under the Contract.

J. **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy
2. serious impairment to bodily functions
3. serious dysfunction of any bodily organ or part

K. **"Emergency Services"** means those inpatient and outpatient health services that are Covered Services, including transportation, needed to evaluate or stabilize an Emergency Medical Condition, which are furnished by a provider qualified to furnish emergency services.

The need for pregnancy-related medical services, including routine prenatal care or delivery, received by a Member traveling outside the Service Area during the third-trimester of pregnancy against medical advice will not be deemed an Emergency, except when Member is outside the Service Area due to circumstances beyond her control.

L. **"EPSDT"** shall mean Early and Periodic, Screening, Diagnosis, and Treatment services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.).

M. **"Exclusion,"** as more fully described in Attachment A, is an item or service which is not a Covered Service under the Contract.

N. **"Experimental or Investigational Treatment"** means any drug, device, therapy, medical treatment or procedure which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals or chemical compounds if, as determined solely by the Health Plan:

The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

The drug, device, therapy, medical treatment, or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other board serving a similar function, or if federal law requires such review and approval;

Reliable Evidence (as that term is defined below) shows that such drug, device, therapy, medical treatment, or procedure has not been proven safe and effective for the treatment of the condition in question, using generally accepted scientific, medical, or public health methodologies or statistical practices;

Reliable Evidence shows that the drug, device, therapy, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of on-going phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or

Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, therapy, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis or the prevailing opinion among experts as demonstrated by Reliable Evidence is that usage should be substantially confined to research settings.

O. **"Grievance"** means a Member's expression of dissatisfaction, including complaints, about any matter other than a matter that is properly the subject of an Appeal.

P. **"Group"** means the Illinois Department of Healthcare and Family Services.

Q. **"Hospital"** is a legally operated facility defined as an acute care or tertiary hospital and an institution licensed by the State and approved by The Joint Commission ("TJC"), the American Osteopathic Association ("AOA") or by the Medicare program.

R. **"Medical Assistance Program"** means the HFS Medical Assistance Program administered by the Illinois Department of Healthcare and Family Services.

S. **"Medical Director"** means a Physician designated by Health Plan to monitor and review the utilization and quality of health services provided to Members.

T. **"Medically Necessary"** means a service that is appropriate, no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Contractor's guidelines, policies, or procedures, for the diagnosis or treatment of a covered illness or injury; for the prevention of future disease; to assist in the Member's ability to attain, maintain, or regain functional capacity; for the opportunity for a Member receiving LTSS to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of the Member's choice; or for a Member to achieve age-appropriate growth and development.

U. **"Member"** shall mean an Eligible Person enrolled in the Health Plan under the Contract.

V. **"Out-of-Area Services"** are those Covered Services arranged or received outside the Service Area and are limited to Emergency Services.

W. **"Participating Provider"** is a Provider, medical group, Hospital, Skilled Nursing Facility, home health agency, or any other duly licensed institution or health professional that has contracted directly or indirectly with Health Plan to provide or facilitate Covered Services to Members, and is currently enrolled as a provider in the Medical Assistance Program. A Participating Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Participating Provider.

X. **"Physician"** is a person licensed under the Medical Practice Act of 1987.

Y. **"Post-Stabilization Services"** means medically necessary non-emergency services furnished to a Member after the Member is Stabilized, in order to maintain such Stabilization, following an Emergency Medical Condition.

Z. **"Primary Care Provider" or "PCP"** means a Participating Provider who has primary responsibility for providing, arranging and coordinating all aspects of a Member's health care. A Member shall select or have selected on his or her behalf a Primary Care Provider. A Primary Care Provider's agreement with Health Plan may terminate at any time and a Member may be required to utilize another Primary Care Provider.

AA. **"Service Area"** means the geographic area within which Health Plan has received regulatory approval to operate and is designated by the Contract under which the Member is enrolled.

BB. **"Short-Term Rehabilitation Therapy"** means rehabilitation therapy that is limited to treatment for conditions which are subject to significant clinical improvement within two (2) months from the first day of care, as determined by Member's Primary Care Provider and Health Plan's Medical Director in advance and on a timely basis unless otherwise explicitly stated in Attachment A.

CC. **"Skilled Nursing Care"** means Covered Services that can only be performed by, or under the supervision of, licensed nursing personnel.

DD. **"Skilled Nursing Facility"** is a facility which is duly licensed by the State which provides inpatient acute skilled nursing care, acute rehabilitation services or other related acute health services.

EE. **"Specialty Care Physician"** is a Physician who provides certain specialty medical care upon referral by a Member's PCP and is currently enrolled as a provider in the Medical Assistance Program and authorized by Health Plan.

FF. **"Stabilization or Stabilized"** means, with respect to an Emergency Medical Condition, and as determined by an attending emergency room Physician or other treating provider within reasonable medical probability, that no material deterioration of the condition is likely to result upon discharge or transfer to another facility.

GG. **"Usual and Customary Charge"** is the charge which is based on the then current prevailing Medical Assistance Program fee schedule in the Member's Service Area. If a Member has a question as to Health Plan's determination of the Usual and Customary Charge in a specific instance, he or she may call Member Services.

HH. **"Woman's Primary Health Care Provider"** ("WHCP") is a physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice who is a Participating Physician and chooses to act as a WHCP.

SECTION II. ELIGIBILITY AND ENROLLMENT

A. **Who is Eligible to be a Member**

An Eligible Person who has enrolled in Health Plan pursuant to the Contract and confirmed by the Department. Also, a newborn child of the Eligible Person who is the Case Holder and who is enrolled in Health Plan shall have coverage from the moment of birth, subject to all applicable provisions of this Certificate. If you have a baby, call your caseworker right away. Then call the Health Plan so we are aware of your baby's birth.

B. **Enrollment**

Enrollment under this Agreement shall operate as follows:

1) Health Plan and the Department, or its contracted client enrollment broker, shall be responsible for the enrollment of Eligible Persons pursuant to agreed-upon procedure. A newborn infant added to the medical assistance case within 46 days of birth will be automatically enrolled in the Health Plan if the mother is the grantee of the case and is enrolled in the Health Plan at the time of birth. Coverage is retroactive to the date of birth in this instance. When a Member gives birth and the infant is added to the medical assistance case after 46 days from birth but before one year from birth, the infant shall be enrolled with the Health Plan. Coverage will be prospective in this instance, with the Effective Date of coverage determined by HFS.

2) Health Plan, as part of its marketing and Member service functions, will educate and assist Eligible Persons to understand their enrollment options, facilitate their contact with the client enrollment broker or, if necessary, submit to the Department, or its contracted client enrollment broker, an approved enrollment form completed and signed by the Eligible Person who is the grantee of the case. An adult Eligible Person who is not the grantee of the case may enroll himself/herself only.

3) A member may change their health plan any time in the first ninety (90) days of enrollment. After that, a member cannot change their health plan except for once a year during the open enrollment period designated by HFS. HFS may additionally allow a Member to disenroll outside of the open enrollment period in the following circumstances upon request:
   - The Member moves out of the Health Plan's service area;
   - Health Plan does not provide a Covered Service sought by the Member due to reasons of conscience;
   - The Member needs related covered services to be performed at the same time, not all of the related services are available through the Health Plan, and the Member's PCP or other Provider determines that receiving the services separately would subject the Member to unnecessary risk;
   - When a change in Member's LTSS Provider (residential, institutional, or employment support) from a Network Provider to a non-Network Provider results in a disruption to residence or employment; or
   - Other reasons, including but not limited to poor quality of care, lack of access to Covered Services, lack of access to Providers experienced in dealing with the Member's health care needs, or, if automatically re-enrolled after loss of eligibility outside of the open enrollment period.

C. **Nondiscrimination**

Enrollment shall be without regard to race, color, religion, sex, national origin, ancestry, age or physical or mental handicap. Health Plan will not discriminate against Eligible Persons on the basis of health status or need for health services.

D. **Delivery of Documents**

Health Plan will provide a Member handbook to each Member upon enrollment, upon request, and with any significant changes.

E. **Notice of Ineligibility**

It shall be the State's responsibility to notify Health Plan of any changes which will affect Member's eligibility.

SECTION III. TERMINATION OF MEMBER'S COVERAGE

A. **Termination**

The Illinois Department of Healthcare and Family services may terminate coverage under this Certificate for a Member as follows:

1) When a Member becomes ineligible for the HFS Medicaid Program or otherwise is not within the population described as being Members under this Contract, or upon the occurrence of any of the following conditions:
   a. Upon the Member's death. Termination of coverage shall take effect at 11:59 PM on the last day of the month in which the Member dies. Termination may be retroactive to this date.

b. When a Member elects to change MCOs during the change period or Open Enrollment Period. Termination of coverage with the previous MCO shall take effect at 11:59 PM on the day immediately preceding the Member's Effective Enrollment Date with the new MCO.
c. When a Member no longer resides in the Service Area. If a Member is to be disenrolled at Health Plan's request under this section, Health Plan must first provide documentation satisfactory to HFS that the Member no longer resides in the Service Area. Termination of coverage shall take effect at 11:59 PM on the last day of the month prior to the month in which HFS determines that the Member no longer resides in the Service Area. Termination may be retroactive if HFS is able to determine the month in which Member moved from the Service Area.
d. When HFS determines that a Member has other significant insurance coverage or is placed in Spend-Down status.
e. When HFS is made aware that a Member is incarcerated in a county jail, Illinois Department of Corrections facility, or federal penal institution. Termination of coverage shall take effect at 11:59 PM on the last day of the month prior to the month in which the Member was incarcerated.
f. When a Member enters Department of Child and Family Services (DCFS) custody. Termination of coverage shall take effect at 11:59 PM on the day prior to the day on which the court grants DCFS custody of the Member.

Health Plan will not seek to terminate a Member's enrollment because of any adverse change in a Member's health status, or because of the Member's utilization of Covered Services, diminished mental capacity, or uncooperative or disruptive behavior resulting from a Member's special needs (except to the extent Member's continued enrollment with Contractor seriously impairs Contractor's ability to furnish Covered Services to the Member or other Members). Further, Health Plan will not seek to terminate enrollment of a Member who attempts to exercise, or is exercising, that Member's Grievance or Appeal rights under this Certificate.

B. **Reinstatement**
A Member shall not be reinstated automatically in the Plan if coverage is terminated by the Department for cause.

If a Member's coverage is terminated due to eligibility cancellation, and if such person's eligibility is regained within 60 days, he or she will automatically be reinstated as a Member of Health Plan and assigned to his or her previous Primary Care Provider and covered under this Certificate. If eligibility is canceled longer than 60 days, membership is not automatically reinstated. A new enrollment application will be required.

C. **Creditable Coverage Certificate**
Health Plan will track periods of "creditable coverage" of each Member. Upon termination of coverage under this Certificate and during the two (2) year period following termination, you may request a Certificate of Creditable Coverage from the Department by calling 888-281-8497.

SECTION IV. COVERED SERVICES AND BENEFITS

Each Member shall select or have selected on his or her behalf a PCP through whom certain primary care medical services shall be provided or coordinated and who will coordinate the other Covered Services to be received by the Member from other Participating Providers. In addition to a PCP, all female Members may select a WHCP if they so choose. It is not required to have or select a WHCP, but the option is available for female Members. American Indian Members may receive services from an Indian Health Care Provider in and outside of the State of Illinois. Members also have the right to choose a Patient-Centered Medical Home (PCMH) certified provider. If a Member receives services through a Physician or healthcare provider other than his or her PCP and such services were not ordered by his or her PCP and authorized by Health Plan, those services will not be covered except in a true Emergency. Members may change their Primary Care Provider by calling Member Services. Changes will be in effect immediately in most circumstances when the Member selects a provider in a fee for service agreement. If the provider has entered into a capitated agreement, changes made prior to the 15th of a month will take effect on the first day of the current month. Changes made on the 15th of the month or after will take effect on the first day of the subsequent month.

A Member shall receive Covered Services from Participating Providers unless otherwise provided in this Certificate, except for family planning services or in an emergency, including medical, surgical, diagnostic, therapeutic and preventive services, as set forth in Attachment A, which are determined to be Medically Necessary and are performed, prescribed, directed or ordered by a Member's Primary Care Provider or WHCP, within the scope of that provider's practice, experience, and training.

When a PCP, WHCP, or other Participating Provider determines services are Medically Necessary and notifies the Health Plan of a recommended course of treatment, and a second course of treatment is determined to be medically equivalent or substantially medically equivalent by Health Plan, Health Plan has the right, at its discretion, and provided that the decision is made on a timely and prospective basis, to cover only the less costly services or benefits rather than those which would otherwise be covered or available under the Contract. This provision does not preclude the physician's right to appeal pursuant to 215 ILCS 134/45. This remains true whether such less costly services or benefits would or would not otherwise be covered. This means, for example, that if both inpatient care in a Skilled Nursing Facility and nursing care in the home on a part time intermittent basis would be medically appropriate, and inpatient care would be less costly, Health Plan can limit coverage to inpatient care. Moreover, Health Plan can limit coverage to inpatient care even if it means extending the quantity of the inpatient benefit beyond that provided in this Certificate.

In order for a proposed course of treatment, service or supply to be considered a Covered Service, that treatment, service or supply must be Medically Necessary (see definition in Section I-T.) A proposed course of treatment, service or supply is not Medically Necessary or a

Covered Service merely because a Participating Physician or Provider prescribes, orders, recommends or approves the service or supply. In addition, the requirements of Medical Necessity apply to all treatments, services or supplies covered under this Certificate, even treatments, services or supplies which are specifically covered by Health Plan or which are not expressly excluded. Thus, a proposed course of treatment, service or supply will not be considered a Covered Service when it is not Medically Necessary even though the treatment, service or supply itself is not specifically listed as an Exclusion and/or may be expressly provided for in Attachment A and/or is otherwise a benefit under the Medicaid Program. Health Plan shall hold Member harmless from any financial responsibility for services that retrospectively are considered not Medically Necessary, unless the Member has committed fraud.

Members may be referred by the PCP to a non-Participating Provider in the event that a Participating Provider cannot meet the medical needs of the patient.

A Member shall not obtain a vested interest in any Covered Service merely by virtue of the fact that the Member has begun to receive that Covered Service. Health Plan may amend or terminate this Certificate as provided herein and Member shall not have a vested interest in continued coverage under this Certificate or any Covered Service.

SECTION V. CONTINUITY OF CARE

A. **New Members**

If a Member is receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment, Health Plan shall assume responsibility for the management of such care and shall be liable for all claims for Covered Services from that date. For hospital stays that would otherwise be reimbursed under the HFS Medical Program on a per diem basis, Health Plan's liability shall begin on the effective date of enrollment. Notwithstanding the foregoing, for hospital stays that would otherwise be reimbursed under the HFS Medical Program on a DRG basis, Health Plan will have no liability for the hospital stay.

If a Member is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Certificate is terminated, Health Plan shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. Health Plan will maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under the Department's Medical Program on a per diem basis, Health Plan shall be liable for payment for any medical care or treatment provided to a Member until the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under the Department's Medical Program on a DRG basis, Health Plan shall be liable for payment for any inpatient medical care or treatment provided to a Member where the discharge date is after the effective date of disenrollment.

Health Plan will provide coordination of care assistance to Prospective Members to access a PCP or WHCP, or to continue a course of treatment, before Health Plan's coverage becomes effective, if requested to do so by the Prospective Member, or if Health Plan has knowledge of the need for such assistance. The Care Coordinator assigned to the Prospective Member shall attempt to contact the Prospective Member no later than two (2) business days after the Care Coordinator is notified of the request for coordination of care.

In the event that the physician of a new Member who is in an active, ongoing course of treatment or is in the third trimester of pregnancy is not a network provider, Health Plan will permit such Member to continue an ongoing course of treatment with such Physician for up to ninety (90) days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patient's Rights Act only if the out-of-network physician agrees to provide such ongoing course of treatment, and if such out-of-network physician agrees to: (i) accept reimbursement at Health Plan's established rates based on a review of the level of services provided, (ii) adhere to Health Plan's QA requirements, (iii) provide necessary medical information related to health care, and (iv) adhere to Health Plan's policies and procedures, including but not limited to procedures regarding referrals.

Health Plan will provide for transition of services in accordance with Section 25 of the Managed Care and Patient's Rights Act (215 ILCS 134/25).

B. **Existing Members**

In the event that a Member's physician leaves Health Plan's network, Health Plan will permit the Member to continue an ongoing course of treatment with the Physician for up to ninety (90) days or through the postpartum period, or as otherwise required by Section 25 of the Managed Care Reform and Patient's Rights Act only if the out-of-network Physician agrees to provide such ongoing course of treatment, and if such out-of-network Physician agrees to (i) accept reimbursement at Health Plan's established rates based on a review of the level of services provided, (ii) adhere to Health Plan's QA requirements, (iii) provide necessary medical information related to health care, and (iv) adhere to Health Plan's policies and procedures, including, but not limited to, procedures regarding Referrals.

SECTION VI. RELATIONSHIP OF PARTIES

A. **Independent Contractors**

The relationship between Health Plan and participating providers is that of an independent contractor relationship; participating providers are not agents or employees of Health Plan, nor is Health Plan, or any employee of health plan, an employee or agent of participating providers. Health Plan shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any participating provider or in any participating provider's

facilities resulting from the participating provider's own negligence in the performance of the participating provider's duties arising from the Member's treatment.

B. **Provider/ Patient Relationship**
Participating Providers maintain the provider/patient relationship with Members and are solely responsible to Members for all health services or treatment afforded or recommended by Participating Providers. Members may refuse to accept certain procedures. Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of their provider/patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate medical care in a manner compatible with a Participating Provider's judgment as to the requirements of proper medical practice. If a Member refuses to follow a recommended treatment or procedure after the Participating Provider has used his or her best efforts to elicit the Member's cooperation, and the Participating Provider believes that no professionally acceptable alternative exists, such Member shall be so advised. In such case, Health Plan will notify the Member to select a new Participating Provider. If the Member has failed to select a new Participating Provider within thirty (30) days of the notice, Health Plan will select a new Participating Provider on the Member's behalf. In addition, Health Plan may notify Illinois Department of Healthcare and Family Services of such noncompliance and request that the Department disenroll the Member from Health Plan. The repeated refusal by the Member to follow prescribed treatment(s) or procedure(s) may result in termination of the Member's coverage, pursuant to Section III, Termination of Member's Coverage. Prior to termination, however, Health Plan will provide Member an opportunity to select an alternative PCP.

Health Plan or a Participating Provider may terminate their contract or limit the numbers of Members that the provider will accept as patients. Health Plan does not promise that a specific Participating Provider will be available to render services throughout the period that a Member is covered by Health Plan. Health Plan will make a good faith effort to give written notice of termination of a Provider within fifteen (15) days of termination where the terminated Provider was a member's Primary Care Physician or otherwise saw the Member on a regular basis

Health Plan shall not intervene with the provision of medical services, it being understood that the traditional relationship between the provider and patient will be maintained. However, Health Plan is not responsible for the payment of medical services in those cases where a particular course of treatment is not a covered service under the Member's Health Plan coverage. Health Plan shall hold Members harmless from any financial responsibility for services that Health Plan retrospectively deems not to be covered, by virtue of not being medically necessary, unless fraud has been committed by the Member.

SECTION VII. WORKERS' COMPENSATION, AUTOMOBILE LIABILITY INSURANCE, MEDICARE AND OTHER HEALTH COVERAGE

A. **Workers Compensation and Automobile Liability Insurance**
The benefits under this Certificate are not designed to duplicate any benefit to which such Members are eligible under Workers' Compensation or Automobile Liability Insurance. All sums payable pursuant to Workers' Compensation and Automobile Liability Insurance for services provided or arranged for Members are payable to and retained by Health Plan. It is also understood that coverage under this Certificate is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation and Automobile Liability Insurance. A Member's failure to pursue his or her Workers' Compensation rights, Automobile Liability benefits (if in force) or the waiver of those rights or benefits shall be considered a violation of this provision.

B. **Medicare**
Except as otherwise provided by applicable Federal law, the benefits under this Certificate for Members age sixty-five (65) and older, or Members otherwise covered by Medicare, do not duplicate any benefit to which such Members are eligible under the Medicare Act, including Part B of such Act, except Medicare copayments and deductibles. Where Medicare is the primary payor, all sums payable pursuant to the Medicare Program for services provided under this Certificate are payable to and retained by Health Plan, or as otherwise directed by Health Plan.

C. **Other Health Coverage**
Any services which have been paid or are payable under any other health plan or health insurance under which a Member is covered is always primary to this coverage which, like the Medical Assistance Program, is always the coverage of last resort.

D. **Members' Cooperation**
Each Member shall complete and submit to Health Plan such consents, releases, assignments and other documents as may be requested by Health Plan in order to obtain or assure reimbursement where Health Plan is the secondary payer under this Section. Health Plan may request that the Department disenroll any Member who fails to so cooperate, including enrolling under Part B of the Medicare Program as soon as possible where Medicare is the primary payor.

SECTION VIII. SUBROGATION

If a Member is injured or becomes ill through the act of a third party, Health Plan shall provide care for such injury or sickness. Acceptance of such services will constitute consent to the provisions of this Section.

In the event of any payments for benefits provided to a Member under this Certificate, Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member has against any person or organization and Health Plan shall be entitled to receive from any such recovery an amount up to the actual amount paid by Health Plan, and if the actual amount paid cannot be determined, then the

Usual and Customary Charges, for the services provided by Health Plan. Member shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Health Plan.

Health Plan shall have a lien on all funds received by Member up to the actual amount paid by Health Plan, and if the actual amount paid cannot be determined, then the Usual and Customary Charge for the services and supplies provided to Member. Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits received under this Certificate. This includes Health Plan's right to bring suit against the third party in the Member's name.

Any such right of subrogation or reimbursement provided to Health Plan under this policy shall not apply or shall be limited to the extent that Illinois statutes or the courts of Illinois eliminate or restrict such rights.

The Member must take such action, furnish such information and assistance, and execute such instruments as Health Plan may require to facilitate enforcement of its rights under this provision. The Member shall take no action prejudicing the rights and interests of Health Plan under this provision.

SECTION IX. UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program is intended to assure the most appropriate level, amount, and quality of care in the most cost effective manner.

A. **Scope of Program**
The utilization management program applies to all covered services. Referral from Member's PCP or WHCP and authorization from health plan is required for all referrals to other healthcare providers, including participating providers and follow-up visits. Covered services subject to this utilization management program include, but are not limited to, the following:

1. All inpatient stays and extension whether in a Hospital, Skilled Nursing Facility, Mental Health Facility or drug and alcohol detoxification facility
2. Home Health Care
3. Short-Term Rehabilitative Services, whether on an inpatient or outpatient basis
4. Mental Health and Psychiatric Services
5. Prosthetic Devices
6. Surgical services whether performed on an inpatient or outpatient basis
7. All Specialty Physician referrals
8. Durable Medical Equipment
9. Alcohol and Substance Abuse Services
10. Services of all non-Participating Providers except in the case of an Emergency
11. HCBS Waiver Services

B. **The Program**
Under the Utilization Management Program, Health Plan will review the PCP's or WHCP's determination that services are Medically Necessary. Factors that will be considered include, but are not limited to, the following elements:

1. Whether the recommended level and/or site of care is Medically Necessary
2. Whether the recommended level and/or site of care is medically appropriate and efficient in light of the available alternatives
3. Whether the duration of treatment is Medically Necessary and/or appropriate

Health Plan will utilize a number of steps in conjunction with the PCP or WHCP in these determinations including, but not limited to: pre-admission review; admission review; continued stay review; and case management.

C. **Use of Genetic Testing**
Health Plan will not seek information derived from genetic testing for use in connection with this Contract for the purpose of disclosing any genetic testing information to anyone not involved in the clinical care of the patient.

SECTION X. GENERAL PROVISIONS

A. **Entire Certificate**
This Certificate and any Attachments hereto, and the individual applications and questionnaires, if any, of the Member constitute the entire agreement between the parties and as of the effective date of coverage, and supersede all other agreements between the parties. No portion of Health Plan's charter, by-laws or other document of Health Plan shall be considered part of this Certificate unless set forth in full herein or attached hereto.

B. **Form or Content of Certificate**
No agent or employee of Health Plan is authorized to change the form or content of this Certificate. Such changes can be made only through endorsement signed by an authorized officer of Health Plan.

C. **Identification Card**

Cards issued by Health Plan to Members pursuant to this Certificate are for identification only. Possession of a Health Plan ID card confers no right to services or other benefits under this Certificate. To receive benefits under this Certificate, the holder of the ID card must, in fact, be an Eligible person. Any other person receiving services or other benefits under this Certificate and any Member assisting such person shall be liable for the actual cost of such services or benefits or, if the actual costs cannot be determined, the Usual and Customary Charges of such services or benefits and Member's coverage may be terminated pursuant to Section III-A(1) and may be in criminal violation of Illinois law.

D. **Authorization to Examine Health Records**
By accepting benefits under the Certificate, the Member consents to and authorizes all healthcare providers, including but not limited to Physicians, Hospitals, Skilled Nursing Facilities and Participating Providers to permit the examination and copying of any portion of the Member's hospital and medical records, when requested by Health Plan, in accordance with the consents obtained in Section VIII-D above. Information from medical records of Members and information received from providers incident to the provider/patient relationship shall be kept confidential and except for uses reasonably necessary in connection with government requirements established by law, may not be disclosed without the consent of the Member.

E. **Notice of Claim**
If submission of a claim is required to receive benefits under this Certificate, such claim shall be allowed only if notice of that claim is submitted to Health Plan within ninety (90) days from the date on which the expense was first incurred. However, if it was not reasonably possible to give notice within the above time limit, and notice was furnished as soon as was reasonably possible, the submission date will be extended accordingly. However, in no event will benefits be allowed if notice of claim is made beyond twelve (12) months from the date on which the expense was incurred, or in the case of an Emergency hospitalization, ninety (90) days from the date Member regained physical or mental capacity to provide such notice, whichever is later. A Member may make a claim to Health Plan by submitting bills from the providers for the healthcare services Member received along with a description of the circumstances surrounding the receipt of the healthcare services and proof of payment if the Member is seeking reimbursement.

F. **Notice**
Any notice under this Certificate may be sent by Certified Mail, Return Receipt Requested or by Federal Express or similar overnight delivery service, including courier, addressed as follows:

Meridian Health Plan of Illinois, Inc.
300 South Riverside Plaza, Suite 500
Chicago, IL 60606

Or, if to a Member, at the last address known to Health Plan.

G. **Interpretation of Certificate**
The laws of the State of Illinois shall be applied to interpretations of this Certificate.

H. **Assignment**
This Certificate is not assignable by Member. A Member's benefits under this Certificate are not assignable.

I. **Gender**
The use of any gender herein shall be deemed to include the other gender and, whenever appropriate, the use of the singular herein shall be deemed to include the plural and vice versa.

J. **Clerical Error**
Clerical error, of the Health Plan in keeping any record pertaining to the coverage hereunder, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

K. **Policies and Procedures**
Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate.

L. **Amendment**
This Certificate shall be subject to amendment or modification upon written notice to Member upon the amendment or modification by Health Plan. By electing medical and hospital coverage under Health Plan or accepting Health Plan benefits, all Members legally capable of contracting agree to all terms, conditions, and provision hereof.

SECTION XI. GENERAL EXCLUSIONS AND LIMITATIONS

Health Plan will not be required to cover the following services:

1. Personal comfort items or services
2. Custodial Care unless provided through HCBS Waiver Services
3. Cosmetic surgery, except for the repair of accidental injury or for improvement of a malfunctioning body part or for correction of congenital deformities evidenced in infancy or reconstructive surgery following a mastectomy
4. Any treatment covered under Workers' Compensation
5. Any treatment covered under programs of the Federal or State Government where the Illinois Department of Healthcare and Family Services has no obligation to pay for such services under the State Medical Assistance Program

6. Health services rendered, including those related to pregnancy, after the termination date of the Member's coverage
7. Diagnostic and/or therapeutic procedures and services related to infertility/sterility. Treatment of infertility, services of sperm banks, artificial insemination procedures including determinations, diagnostic procedures and fertility drugs used in preparation of treatment. Gamete intra-fallopian tube transfer, embryo transfer, embryo freezing and cost of donor sperm
8. Early intervention services, including case management, provided pursuant to the Early Intervention Service System Act
9. Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund
10. Behavioral Training and Modification including biofeedback, neuro-muscular re-education, hypnotherapy, sleep therapy, vocational rehabilitation, sensory integration, play therapy, educational therapy, and recreational therapy
11. Dietary supplements that are not Medically Necessary
12. Exercise, health club membership, self-help, hygienic, and beautification equipment
13. Gender (sex) transformation, transsexual surgery or any procedures or treatment designed to alter physical characteristics of the Member to those of the opposite sex, and any other treatment or studies related to sex transformations
14. Medications to enhance athletic performance
15. Military service connected care, care for military service-connected disabilities and conditions for which the Member is legally entitled and for facilities which are in the Service Area
16. Personal or comfort items, such as, but not limited to, radio, television, telephone, guest meals, cosmetics, dietary supplements that are not Medically Necessary, and health or beauty aids, personal lodging, meals, travel expenses and all other non-medical expenses
17. Replacement prescription medications involving fraud of the Member
18. Reversal of voluntary surgically-induced infertility
19. Non-emergency transportation services that are not Medically Necessary
20. Complications resulting from a non-covered service will be determined on a case-by-case basis
21. Any treatment required as the result of war, or the act of war occurring after the Individual Effective Date, in the event of a major disaster or epidemic

The benefits under this certificate are intended to be equal to those covered under the medical Assistance Program unless otherwise expressly provided, consistent with the contract. Exclusions and benefits are consistent with the Medical Assistance Program fee schedule provided by the medical assistance program for the State of Illinois' Department of Healthcare and Family Services. In addition, the exclusions listed above are not exhaustive and shall automatically be supplemented and revised to conform to the services covered or excluded by the Medical Assistance Program and the Contract, and any amendments thereto.

Attachment A
Covered Services and Benefits, Limitations and Exclusions

SECTION I. COVERED SERVICES AND BENEFITS

The benefits under this Certificate are intended to be equal to those covered under the Medical Assistance Program unless otherwise expressly provided, consistent with the Contract.

In order for a service to be a covered service it must be Medically Necessary and authorized by Health Plan if such authorization is required.

A. **Physician Services**

1. **Participating Provider Services**. Medically Necessary physician services received in the office of Member's PCP, WHCP or in the office of a Participating Specialist.

2. **Surgical Services.** Medically Necessary surgical services in a Participating Hospital, a Participating Hospital's outpatient surgical facility, ambulatory surgical facility, or in a Participating Provider's office (where medically appropriate) including surgical assistants where Medically Necessary and Medically Necessary anesthesiologist services performed in connection with surgical services. Reconstructive surgery incident to a mastectomy is covered, provided that the mastectomy is performed after July 1, 1981. For purposes of this Contract, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons, as determined by a Participating Provider. Removal of breast implants when the removal of the implants is medically necessary treatment for a sickness or injury and the implants were not implanted solely for cosmetic reasons.

3. ***Professional Services in Hospital.*** *Medically Necessary services by a Participating Provider for visits, examinations and consultations, when such Member is an inpatient receiving covered Inpatient Services in a Participating Hospital or Participating Skilled Nursing Facility.*

4. ***Services In The Home.*** *Medically Necessary services in the Member's home by a Participating Provider if the Participating Provider determines that the Member is too ill or disabled to be seen during regular working hours at the Provider's office.*

B. **Inpatient Hospital Services**

1. Hospital stays in a semi private room, meals and general nursing care; a private room when Medically Necessary, ordered by a Participating Provider and approved by Health Plan
2. Special diets and dietitian services when Medically Necessary
3. Use of operating room and related facilities, and specialized treatment rooms
4. Intensive care unit and services
5. Anesthesia and oxygen services
6. Surgical and anesthetic supplies furnished by the hospital as a regular service
7. Surgical implant devices and supplies used by a Member while an inpatient
8. Hospital ancillary services, i.e., laboratory, pathology, radiology, radiation therapy, inhalation and respiratory therapy, whether or not services are provided by a Participating Physician or Participating Provider
9. Drugs, medications, and biologicals when prescribed for use as an inpatient
10. Blood transfusion services, including the administration of whole blood, blood products (blood components and derivatives) and blood plasma. Autologous blood collection and storage, if Medically Necessary, for a specific planned hospital admission
11. Diagnostic and therapeutic services
12. Coordinated discharge planning services, including the planning of such continuing care as may be Medically Necessary
13. Organ transplantation procedures using a transplant Provider certified by HFS. The Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the Federal Department of Health and Human Services will be consulted to respond to a request for determination within ninety (90) days whether such procedure is experimental or investigational or that there is insufficient data or experience to determine whether an organ transplantation procedure is clinically acceptable
14. Post-parturition care of a minimum of forty-eight (48) hours of Inpatient care following a vaginal delivery for the mother and newborn or a minimum of ninety-six (96) hours of Inpatient care following a delivery by caesarean section for the mother and newborn; provided that a shorter length of Hospital Inpatient stay may be provided if the Member's Participating Provider determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and newborn meet the appropriate guidelines for a shorter length of stay based on evaluation of the mother and newborn. In the event a shorter length of stay occurs, a post-discharge Physician office visit or in-home nurse visit within the first forty-eight (48) hours of discharge will be covered
15. Inpatient coverage for post-mastectomy care for a length of stay determined by the Member's Participating Provider to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and upon evaluation of the Member. If Medically Necessary, a post-discharge Physician office visit or in-home nurse visit to verify the condition of the Member within the first forty-eight (48) hours of discharge will also be covered

C. **Diagnostic Testing and Laboratory Services**

Diagnostic services, including diagnostic laboratory services, imaging and diagnostic and therapeutic radiological services.

D. **Short-Term Rehabilitation Therapy**

For each acute condition or complex of acute interrelated conditions (multiple problems and/or sites in the same body region) which are related to the same acute causal event but not including conditions for which rehabilitative services have previously been provided, Medically Necessary Short-Term Rehabilitation Therapy services (as defined in Section I-CC) limited to speech, physical, and occupational rehabilitative therapy for acute conditions which are directed at improving the physical functioning of Member will be provided when ordered by Member's PCP and authorized by Health Plan's Medical Director in advance and on a timely basis. Coverage of cardiac and pulmonary rehabilitation is included. For Members age 21 and over, Coverage is limited to twenty (20) visits per category of therapy per year until ***October 1, 2014.***

E. **Home Health Services**

Medically Necessary part-time, intermittent home health services provided by a Participating Provider, when the Member is homebound for medical reasons, when and to the extent prescribed by a Participating Provider in accordance with a home health treatment plan and authorized by Health Plan. Such home health services include:

1. *Skilled nursing services provided by a registered nurse or licensed vocational nurse*
2. *Home health aide services under the supervision of a registered nurse, excluding meals, child care, in-home day care, and housekeeping services*
3. *Physical, occupational or speech therapy, subject to the limitations of Section II-D, Short-Term Rehabilitation, Attachment A*
4. *Laboratory services prescribed by a Participating Provider and administered by a Participating Provider, to the extent the same would have been Covered Services if the Member had remained in the Hospital or Skilled Nursing Facility*

F. **Skilled Nursing and Intermediate Care Facilities**

Medically Necessary non-acute care skilled nursing or immediate care services in a Skilled Nursing Facility or an immediate care facility (or equivalent care provided at home because a skilled nursing facility is not available) which is provided by a Participating Provider is Covered. Coverage for custodial care is only available to Members determined eligible by the State, as evidenced by the Member's presence on the Patient Credit File distributed by HFS.

G. **Hospice**

Hospice care services provided as part of an established hospice program are covered when a Member's condition is terminal and Hospice care would be appropriate. Coverage is provided for:

1. Inpatient Hospice Care: short-term inpatient care in a licensed hospice facility when skilled nursing services are required and cannot be provided in other settings;

2. Outpatient Hospice Care: covered when intermittent skilled nursing services by a registered nurse or licensed practical nurse are required or when medical social services under the direction of a Physician are required. Outpatient Hospice Care is any care provided in a setting other than a licensed hospice facility. Hospice care provided while in a Hospital or skilled nursing facility is considered outpatient hospice care.

3. Respite Care: Respite care in a facility setting is a Covered Benefit as outlined in the Plan's medical policies.

H. **Preventive Health Services**

1. **Periodic Health Appraisals.** Health appraisals from birth by the Member's Primary Care Provider including:
   a. Periodic physical examinations
   b. Hearing and vision screening as set forth in Attachment A, Section II-G(5), below
   c. Routine laboratory testing and screening as set forth in Section C of this Attachment A
   d. Blood pressure testing
   e. Pelvic examination as set forth in Attachment A, Section II-G(2), below
   f. Mammography testing as set forth in Attachment A, Section II-G(4), below
   g. EPSDT Services as set forth in Attachment A, Section II-G(9), below

2. **Periodic PAP Smear, Breast And Pelvic Examination**. Female Members may receive an annual PAP smear, breast and pelvic examination, including cervical-cytological testing. This examination may be performed by the PCP or WHCP, at the option of the Member, and does not require a referral from Health Plan.

3. **Immunizations**. Adult Members may receive immunizations as recommended by the U.S. Public Health Service and prescribed by the Member's PCP. Child Members may receive immunizations in accordance with the recommendations of the American Academy of Pediatrics and prescribed by the child Member's Primary Care Provider. Immunizations primarily for the Member's personal convenience including but not limited to, travel, school (for adult Members), work (for adult Members) and recreational purpose are not covered.

4. **Mammography**. Female Members may receive mammography for screening or diagnostic purposes upon referral by the Member's PCP or WHCP and as set forth herein. Low-dose mammography for female Members 35 years or older for the detection of occult breast cancer is covered as follows:

   a. A baseline mammogram for women 35 to 39 years of age
   b. An annual mammogram for women 40 years of age or older
   c. As indicated for women with personal or family history

   For the purposes of this Section only, the term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, and image receptor, with radiation exposure delivery of less than one (1) rad per breast for two (2) views of an average size breast.

5. **Hearing Screening.** Vision and hearing screening for Members to determine the need for vision and hearing correction as determined by the Member's PCP.

6. **Sexually Transmitted Diseases.** Testing for sexually transmitted diseases through the Member's PCP.

7. **Health Education Services.** Members may receive from Health Plan or the Member's PCP health education services and/or materials, including:

   a. Information regarding personal health behavior and health care, and instructions on achieving and maintaining physical and mental health and preventing illness and injury
   b. Information and recommendations regarding the optimal use of healthcare services provided by Health Plan or healthcare organizations affiliated with Health Plan
   c. Information regarding service agencies (but services of such agencies are not Covered Services), including adoption agencies, medical social services, ancillary services for the treatment for abuse of, or addiction to, alcohol and drugs
   d. Basic infertility counseling, consisting of medical/sexual history review and fertility awareness education, but not infertility medications or procedures.

8. **Circumcisions** performed within the first six weeks of birth and circumcisions performed thereafter if Medically Necessary.

9. **EPSDT Services.** Members who are under 21 years of age are eligible to receive EPSDT Services, including screening examinations and immunizations that are consistent with the Medical Assistance Program. Child Members may receive Covered Services to treat a covered condition detected pursuant to such EPSDT Services in accordance with Health Plan's UM/QA Protocols. Psychological testing by Participating Provider for a child Member is a Covered Service when ordered by Member's PCP and authorized by Health Plan pursuant to its UM/QA Protocols. EPSDT services exclude shift nursing for Members in the HCBS Waiver for individuals who are medically fragile and technology dependent.

10. **Prostate-Specific Antigen Tests.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, male Members age fifty (50) and over, African-American male Members age forty (40) and over and male Members with a family history of prostate cancer age forty (40) and over may receive an annual digital rectal examination and a prostate-specific antigen test upon the recommendation of the Member's PCP.

11. **Colorectal Cancer Screening.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, Members who are at least fifty (50) years old or Members classified as high risk for colorectal cancer because the Member or a first-degree family Member of the Member has a history of colorectal cancer who are at least thirty (30) years old are eligible to receive colorectal cancer screening with sigmoidoscopy or fecal occult blood testing every three (3) years.

12. **Diabetes Self-Management and Training.** Unless otherwise required, amended or revised by the Department or the Illinois Division of Insurance, Members diagnosed with Type 1 Diabetes, Type 2 Diabetes or gestational diabetes mellitus are eligible to receive diabetes self-management training and education. "Diabetes self-management training" means instruction in an outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.

    Coverage shall be provided for the following equipment when Medically Necessary and prescribed by the Member's PCP:
    a. Blood glucose monitors
    b. Blood glucose monitors for the legally blind
    c. Cartridges for the legally blind
    d. Lancets and lancing devices

    Coverage shall be provided for the following pharmaceuticals and supplies when Medically Necessary and prescribed by the Member's PCP:
    a. Insulin
    b. Syringes and needles
    c. Test strips for glucose monitors
    d. FDA approved oral agents used to control blood sugar
    e. Glucagon emergency kits

    Coverage shall be provided for regular foot care exams by a Participating Provider.

    If authorized by a Participating Provider, diabetes self-management training may be provided as a part of an office visit, group setting, or home visit.

I. **Pregnancy, Maternity, and Newborn Care**
Prenatal care, prenatal HIV testing, prenatal diagnostic procedures in cases of high risk pregnancy, labor and delivery rooms, delivery, special procedures such as Cesarean section, anesthesia, antepartum and postpartum care, post-natal care for newborn infants and services for any conditions resulting from pregnancy or from childbirth and any complications thereof. The coverage, benefits and services for newborn infants shall include illness, injury, congenital defects, birth abnormalities and premature birth.

J. **Family Planning Services**

Family Planning Services and counseling are covered and available as outlined below if prescribed by Member's PCP or WHCP and authorized, if applicable. These services include information, physical exam and counseling during a visit, annual physical exam for family planning purposes, pregnancy testing, voluntary sterilization, related laboratory and diagnostic testing, instruction and medical counseling services on family planning issues, including the use of contraceptive devices and birth control medication. Birth control medication, contraception devices and physician services for the insertion and removal of an intra-uterine device (IUD) are covered. Family planning services may also be obtained out of network, without a referral.

K. **Emergency Services**

1. **Medical Care and Notification.** Medical care is available through Participating Providers seven (7) days a week, twenty-four (24) hours a day. If injury or illness requires Emergency Services, the Member must notify his or her PCP or Health Plan within twenty-four (24) hours of an emergency admission or within twenty-four (24) hours of when the Member is able to notify the Health Plan. The definition of an emergency is set forth in Section I-J of the handbook. When appropriate, Emergency Services will include such inpatient services as necessary to stabilize the Member. If an Emergency occurs, the Member should go to the nearest hospital emergency department immediately and notify his or her PCP as soon as possible. Medical care for Emergencies includes services of a hospital emergency department, inpatient services, outpatient visits and referrals for emergency mental health problems.

2. **Post-Stabilization Medical Services.** Post-Stabilization Medical Services, which would be otherwise covered if provided by a Participating Provider, will be covered when provided by a non-Participating Provider when the following conditions are met:
   a. The non-Participating Provider has obtained approval to provide such services from Health Plan; or
   b. The non-Participating Provider made a good faith attempt to contact the Health Plan and Health Plan did not respond or deny such services within one (1) hour of the non-Participating Provider's attempt to contact Health Plan; or
   c. The services are provided within one (1) hour of the non-Participating Provider contacting the Health Plan for authorization; or
   d. The services are provided after Health Plan and the non-Participating Provider are unable to reach an agreement on the Member's care, until such time as a Participating Provider may be contacted and either concurs with the non-Participating Provider's plan of care or agrees to assume responsibility for the Member's care.

3. **Emergency Ambulance Service.** Members may receive Medically Necessary ambulance services in an emergency to transport the Member to the nearest hospital emergency department without an order from his or her PCP or authorization of Health Plan. Services of an air ambulance are covered up to the cost of ground ambulance services for a similar level of care and similar distance of travel.

4. **Payment.** Payment for services of non-Participating Providers shall be subject to Usual and Customary Charges for such services as defined herein. Except for extenuating circumstances, all claims which may have been paid by Member for Emergency Services or Post-Stabilization Medical Services, whether for Provider or Hospital, must be submitted to Health Plan within one (1) year of the date of service in order for such expenses to be considered for reimbursement.

5. **Follow-Up Care.** Follow-up care will be covered only when (a) provided to the Member by a Participating Provider; (b) when determined to be Medically Necessary; and (c) ordered by Member's PCP.

L. **Urgent Care**

An urgent condition is an illness or injury that will not cause further disability or death if not treated immediately, but requires professional attention to prevent it from developing into a greater threat. Urgent care centers should be used only if the Primary Care Provider is not available, such as after hours. Examples of urgent care situations include, but are not limited to, the following:

- Sore throat or cough
- Back pain
- Tension headache
- Earache
- Flu or cold symptoms
- Frequent urination
- Minor sickness
- Minor injury

Visits to an urgent care center are a Covered Benefit. For non-emergency problems, Members should contact their PCP.

M. **Non-Emergency Ambulance or Medical Transport Services**

In accordance with Health Plan's transportation policy, Medically Necessary ambulance or medical transport services, for Members, from a Participating Provider or Non-Participating Provider between medical facilities when Medically Necessary, prescribed by a Participating Provider and authorized by Health Plan. The transportation benefit includes transportation to medical appointments, pharmacy and medical equipment providers, and Women, Infants, and Children (WIC) food assistance.

N. **Allergy Testing**

Allergy testing when Medically Necessary, prescribed by a participating provider and authorized by Health Plan.

O. **Dental Services**

Dental services are Covered when: (1) necessary to relieve pain or infection, preserve teeth, or restore adequate dental function; (2) diagnostic, preventive, or restorative services, endodontics, prosthodontics, orthodontics, or oral surgery included on Table D of the HFS Schedule of Dental Procedures; and (3) performed by the dentist or under the direct supervision of the dentist, or for oral health

screening and fluoride varnish services, performed by or under the direct supervision of an enrolled licensed dentist, physician, or APN.

Orthodontic services are Covered only for patients under the age of 21 and are limited to (1) treatment necessary to correct a condition that scores 28 points or more on the Handicapping Labio-Lingual Deviation Index (HLD); or (2) treatment necessary to correct cleft palate, deep impinging bite with signs of tissue damage (not just touching palate), anterior crossbite with gingival recession, or severe traumatic deviation (i.e., accidents, tumors, etc.).

P. **Orthopedic and Prosthetic Devices**
Medically Necessary prostheses and orthoses are a covered benefit, excluding experimental and investigational devices or devices not provided in connection with an illness or injury to the Member.

Q. **Out-of-Area Services**
Medically Necessary Covered Services from non-Participating Providers outside the Service Area of Health Plan, but only as specified below. Payments by Health Plan for such services are limited to charges which do not exceed the Department's reimbursement rates.

If an injury or sudden illness requiring Emergency care occurs when a Member is temporarily outside the Service Area, the Member should obtain Emergency care at the nearest medical facility or emergency department. Covered Emergency services include Medically Necessary ambulance services and Emergency Hospital Services. If the Member is admitted as an inpatient, the Member should ask the hospital to notify Health Plan as soon as possible but no later than twenty-four (24) hours after admission. Continuing or follow-up treatment by non-Participating Providers for accidental injury or emergency illness is limited to medically necessary services required before the Member can, when it is medically appropriate, return to the Service Area.

If Member is required by the provider of service to pay for medically necessary Out-of-Area services, Member must, except for extenuating circumstances, submit all receipts for out-of-pocket expenses to Health Plan within ninety (90) days of the date of service in order for such expenses to be considered for reimbursement.

The need for pregnancy-related medical services, including routine prenatal care or delivery, received by a Member traveling outside the Service Area during the third-trimester of pregnancy against medical advice will not be deemed an emergency, except when Member is outside the Service Area due to circumstance beyond her control.

R. **Mental Health Services**
1. **Inpatient Mental Health and Substance Abuse Services.** Medically necessary non-emergent Inpatient mental health and substance abuse services are covered when authorized in advance by Health Plan. Health Plan requires participating providers to complete a behavioral health assessment.

2. **Outpatient Mental Health Services.** Medically necessary individual outpatient non-emergent Mental Health Services for evaluation, short-term treatment or crisis intervention are Covered without prior authorization. Health Plan requires participating providers to complete a behavioral health assessment.

   In addition, medically necessary Emergency Services do not require authorization in advance by Health Plan.

S. **Detoxification and Treatment of Alcoholism and Drug Abuse**
1. **Inpatient Care.** Medical treatment for detoxification or medical complications of drug and alcohol abuse on an inpatient basis when determined to be medically necessary by Member's PCP and approved in advance by Health Plan is a covered benefit. In addition, Inpatient rehabilitative services for alcohol or drug abuse are limited to thirty (30) days per calendar year for adults. There is no limitation for Inpatient rehabilitation services for alcohol or drug abuse for Members under the age of twenty-one (21), Members under the age of twenty-one (21) as an EPSDT benefit or pregnant Members. Care in a day hospital, residential non-hospital or intensive outpatient treatment mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by Member's PCP. Thus, the number of remaining annual inpatient days a Member is eligible for will be reduced by one-half day for each day the Member is enrolled in a day hospital, residential non-hospital or intensive outpatient environment pursuant to a determination of appropriateness by Member's PCP. Inpatient detoxification services are only covered if Member has not been previously admitted for inpatient detoxification services in the sixty (60) days prior to admission.

2. **Outpatient Treatment.** Medical treatment for detoxification or medical complications of drug and alcohol abuse on an outpatient basis when determined to be medically necessary by Member's PCP and approved in advance by Health Plan is a covered benefit. In addition, Medically Necessary outpatient counseling for alcohol and drug abuse as appropriate for evaluation, crisis intervention, and short-term treatment is a covered benefit and is limited to twenty-five (25) hours per calendar year. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by Member's PCP. Thus, the number of remaining annual individual outpatient counseling visits a Member is eligible for will be reduced by one-half visit for each group outpatient visit received by Member pursuant to a determination of appropriateness by Member's Primary Care Provider. There is no limit for counseling for Members under the age of twenty-one (21) as an EPSDT benefit or for pregnant Members. Outpatient services must be rendered by a Participating Provider.

T. **Sexual Assault or Abuse**
Any examination, treatment or testing of a victim of Sexual Assault or Abuse, or any attempt to commit Sexual Assault or Abuse, shall be covered in full. Sexual Assault or Abuse means any offense as defined in Section 12-13 through 12-16 of the Illinois Criminal Code, as amended from time to time.

U. **Pharmacy**
When prescribed or authorized by the PCP, selected Prescription drugs, including family planning drugs, devices, or supplies are a Covered Benefit. The drug must be a drug approved by the Plan and listed in the Plan formulary or prior authorized. Selected over-the-

counter analgesics, laxatives, antacids, iron supplements, and family planning drugs, devices, or supplies are a Covered Benefit when ordered by Prescription and authorized by the Member's PCP. Additionally, Medically Necessary medical supplies such as catheters, testape, clinitest, and similar supplies; bag frames and supplies for colostomies, ileostomies, and ureterostomies; and dressings and dressing supplies are a Covered Benefit when order or authorized by the Member's PCP.

All Prescription Drugs must be filled at a Plan Participating pharmacy. A complete list of covered drugs is found on the Plan's pharmacy formulary, available upon request or on the Plan's website at ilmeridian.com.

V. **Durable Medical Equipment**
Durable and non-durable medical equipment is covered when authorized by a PCP and approved by Health Plan. Equipment includes, but is not limited to, standard wheelchairs, walkers, crutches, traction equipment, standard hospital beds, oxygen, and oxygen administration equipment, as well as other respiratory equipment and supplies. Also included are amino acid based elemental formulas, regardless of delivery method for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary.

W. **Vision Services**
Optometrist services and optical services and supplies are a covered benefit. Adult eyeglasses are limited to once every two (2) years. For children in the Chicago Public School (CPS) system, coverage will additionally be provided for the manufacture of eyeglasses by a CPS-contracted vendor for the CPS child.

X. **Nutritional Counseling and Weight Management**
Nutritional services and counseling provided by a licensed dietician and referred by a Participating Provider are a Covered Benefit when delivered for certain medical conditions. Additionally, participation in a guided weight management program such as Weight Watchers® is a Covered Benefit when prior authorized by the Plan.

Y. **Enumerated Covered Services**
To the extent not identified above, the following enumerated services shall be included as Covered Services under this Certificate and will be provided to Members whenever Medically Necessary:

- Abortion
- Assistive/augmentative communication
- Audiology services, physical therapy, occupational therapy and speech therapy
- Behavioral health services, (inpatient and outpatient)including subacute alcohol and substance abuse services and mental health services
- Blood, blood components and the administration thereof
- Bone mass measurement and diagnosis and treatment of osteoporosis
- Certified hospice services
- Clinic Services (as described in 89I11. Adm. Code, Part 140.460)
- Diagnosis and treatment of medical conditions of the eye provided by a physician
- Durable and nondurable medical equipment and supplies
- Hearing aids, when supported by PCP referral and subject to prior authorization
- Emergency Services
- Family Planning Services
- Home Health Care Services
- Inpatient hospital services (including dental hospitalization in case of trauma or when related to a medical condition including medical detoxification)
- Laboratory and x-ray services
- Medical procedures performed by a dentist
- Nurse midwife services
- Nursing facility services
- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incident to mastectomy
- Outpatient hospital services
- Physicians' services, including psychiatric care
- Pharmaceutical products provided by an entity other than a pharmacy
- EPSDT
- *Services to Prevent Illness and Promote Health in accordance with subsection (c) hereof*
- Advanced Practice Nurse services
- Respiratory equipment and supplies
- Chiropractic services for Members under age 21
- Dental services
- FQHC, RHC, and other encounter-rate clinic visits
- Nursing care for Members under age twenty-one (21) not in the HCBS Waiver for individuals who are Medically Fragile and Technology Dependent, pursuant to 89 Ill. Admin Code Section 140.472
- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for Members under age twenty-one (21), pursuant to 89 Ill. Admin Code 146, Subpart D
- Subacute alcoholism and substance abuse services pursuant to 89 Ill. Admin. Code Sections 148.340 through 148.390 and 77 Ill. Admin. Code Part 2090
- Mental health services provided under the Medicaid Clinic Option or Medicaid Rehabilitation Option
- Practice visits for members with special needs

- Renal dialysis services
- Telemonitoring equipment to transmit health data electronically to the Plan for Members determined eligible for the telemonitoring program
- Transportation to secure Covered Services.
- Transplants covered under 89 Ill. Adm. Code 148.82 (using transplant providers certified by the Department, if the procedure is performed in the State)
- Podiatric care
- 24 hour, 7 day a week access to a Nurse Advice telephone line.
- Services to prevent illness and promote health, including the following:
  a. EPSDT services in accordance with 89 Ill. Adm. Code 140.485
  b. Preventive Medicine Schedule which shall address preventive healthcare issues for Members twenty-one (21) years of age or older
  c. Maternity care for pregnant Members
  d. Family planning services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, voluntary sterilization, insertion or injection of contraceptive drugs or devices, and related laboratory and diagnostic testing.
  e. The Plan's providers shall screen Members who are children six months through six years of age for lead poisoning. These children must be tested as required in the Healthy Kids Early and Periodic Screening, Diagnosis and Treatment Program (89 Ill. Adm. Code 140), as defined in the Handbook for Providers of Healthcare Services. Every provider who diagnoses, or health care provider, nurse, hospital administrator or public health officer who has verified information of any person who has a level of lead in the blood, starting with a confirmed lead level of 10 mcg/dL is required to report. Children who have elevated screening results shall have follow-up testing. Elevated capillary results 10 mcg/dL and above shall be confirmed by a venous sample
- Benefits for members with HCBS waivers (outlined in grid below). HCBS Waiver Services are only available to those members determined eligible by the appropriate state agency administering the waiver program. Health Plan does not perform eligibility determinations.)

HCBS Waiver Benefits	
Waiver Type/ LTSS	Benefits
Aging Waiver Service	• Adult Day Care • Transportation to Adult Day Care Center • Homemaker Services • Personal Emergency Response System
Individuals with Disabilities Waiver	• Adult Day Care • Transportation to Adult Day Care Center • Personal Emergency Response System • Home Modifications • Home Delivered Meals • Home Health Aide • Homemaker Services • Occupational Therapy • Personal Assistant • Physical Therapy • Respite • Skilled Nursing • Intermittent Nursing • Specialized Medical Equipment and Supplies • Speech Therapy
HIV/AIDS Waiver	• Adult Day Care • Transportation to Adult Day Care Center • Personal Emergency Response System • Home Modifications • Homemaker Services • Home Delivered Meals • Personal Assistant • Physical Therapy • Occupational Therapy • Respite • Skilled Nursing • Home Health Aide • Speech Therapy • Specialized Medical Equipment and Supplies • Intermittent Nursing
Individuals with Brain Injury Waiver	• Adult Day Care • Transportation to Adult Day Care Center • Behavioral Services

	• Day Habilitation • Personal Emergency Response System • Home Modifications • Home Delivered Meals • Homemaker Services • Occupational Therapy • Personal Assistant • Prevocational Services • Respite • Intermittent Nursing • Skilled Nursing • Home Health Aide • Specialized Medical Equipment and Supplies • Speech Therapy • Supported Employment Services • Physical Therapy
Supported Living Facilities Waiver	• Nursing Services • Personal Care • Medication Assistance • Laundry • Housekeeping • Maintenance • Social and Recreational Programming • Daily checks • Ancillary services • 24 hour response/security staff • Health Promotion and exercise • Emergency call system • Quality Insurance Plan • Management of Resident Funds, if applicable
Children who are Medically Fragile/Technology-Dependent Waiver	• Home Modifications • Placement Maintenance Counseling • Respite • Nurse Training • Family Training

Any services which have been paid or are payable under any other health plan or health insurance under which a Member is covered is always primary to this coverage and, like the Medical Assistance Program, is always the coverage of last resort.

SECTION II. EXCLUSIONS AND LIMITATIONS

A. **Exclusions**

The benefits under this Certificate are intended to be equal to those covered under the Medical Assistance Program unless otherwise expressly provided, consistent with the Contract. Exclusions and benefits are consistent with the Medical Assistance Program fee schedule provided by the Medical Assistance Program for the State of Illinois' Healthcare and Family Services.

The following services and benefits shall not be included as covered services:

1. Mental health clinic services as provided through a community behavioral health provider as identified in 89 Ill. Adm. Code 140.452 and 140.454 and further defined in 59 Ill. Adm. Code, Part 132 "Medicaid Community Mental Health Services Program"

2. Services provided in an Intermediate Care Facility for the Mentally Retarded/Developmentally Disabled and services provided in a nursing facility to mentally retarded or developmentally disabled Members

3. Early intervention services, including case management, provided pursuant to the Early Intervention Services System Act (325 ILCS 20 et seq.)

4. Services provided through local education agencies that are enrolled with the Department under an approved individual education plan (IEP)

5. Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund

6. Services that are experimental and/or investigational in nature

7. Services provided by a non-Affiliated Provider and not authorized by the Contractor, unless this Contract specifically requires that such services be covered

8. Services that are provided without first obtaining a prior authorization as set forth in the Member Handbook

9. Medical and/or surgical services provided solely for cosmetic purposes

10. Diagnostic and/or therapeutic procedures related to infertility/sterility

11. Early intervention services, including case management, provided pursuant to the Early Intervention Service System Act

12. Services that are provided in a State Facility operated as a psychiatric hospital as a result of a forensic commitment.

13. Services that are provided through a Local Education Agency (LEA)

B. **Limitations**

1. ***General Limitations -****In the event that, due to circumstances not within the control of Health Plan, including but not limited to a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of significant part of Participating Provider's personnel or similar causes, the rendition of professional or hospital services provided under this Certificate is delayed or rendered impractical, Health Plan shall make a good faith effort to arrange for an alternative method of providing coverage. In such event, Health Plan and Participating Providers shall render the Hospital and professional services provided under the Contract insofar as practical, and according to their best judgment; but Health Plan and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.*
2. ***Out-of-Area Care -*** *Out-of-area benefits and services are limited to situations in which care is required immediately and unexpectedly; elective or specialized care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. For example, the need for pregnancy-related medical service by a Member traveling outside the Service Area against medical advice during the third-trimester of pregnancy will not be deemed an Emergency, except when the Member is outside the Service Area due to circumstances beyond her control. However, unanticipated complications of pregnancy or premature delivery occurring before the Member had entered the third-trimester of pregnancy are covered outside the Service Area.*

   Continuing or follow-up treatment for an emergency situation is limited to care required before the Member can, without medically harmful or injurious consequences, return to the Service Area. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of this Certificate.

The following services and benefits shall also be limited as Covered Services:

1. Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a DPA Form 2189 must be completed and filed in the Member's medical record.

2. If a hysterectomy is provided, a DPA Form 1977 must be completed and filed in the Member's medical record.

Attachment B
Member Services Department

Health Plan maintains a Member Services Department which is available to respond to your questions or concerns twenty-four (24) hours a day, seven (7) days a week. If you have any questions regarding provisions of this Certificate, how to obtain services under this Certificate, or have other questions, please contact Member Services at 866-606-3700. If you are hearing impaired, call the Illinois Relay at 711.
Member Services will:

- *Replace identification cards*
- *Assist in scheduling appointments*
- *Resolve Member complaints*
- *Assist with referrals to specialists*
- *Assist with PCP changes and WHCP changes*
- *Assist in filing grievances and appeals*