meridianhealth

Illinois *member* handbook.

Effective date: July 1, 2021
Member services: 866-821-2308
TTY/TDD: 711

ILmeridian.com

Welcome to MeridianHealth

Managed Long Term Services and Supports (MLTSS)

Welcome to MeridianHealth (Meridian)! The Managed Long Term Services and Supports (MLTSS) Program coordinates Medicaid-only services for members receiving both Medicare and Medicaid. If you qualify for Medicare and Medicaid services, and you are eligible for a Home and Community-Based Services (HCBS) waiver program or Nursing Facility Program, you may be enrolled in MLTSS. The program coordinates care for nursing home services, waiver benefits, behavioral health and non-emergent medical transportation.

The goal of the MLTSS program is to help you:

- Improve your well-being
- Avoid hospital re-admissions
- Return to and/or remain living in the residence of your choice (including your home and community) and increase your quality of life

Important Phone Numbers & Contacts

In an Emergency	911
Meridian Member Services	866-821-2308
TTY for the Hard of Hearing	711
Transportation (non-emergency)	866-796-1165
Behavioral Health Services	866-796-1167
Illinois Client Enrollment Broker (ICEB)	877-912-8880
Nurse Advice Line (24 hour)	866-821-2308
Website	ilmeridian.com

Service Area

You are eligible for Meridian services under the MLTSS program. Meridian operates in all counties in Illinois.

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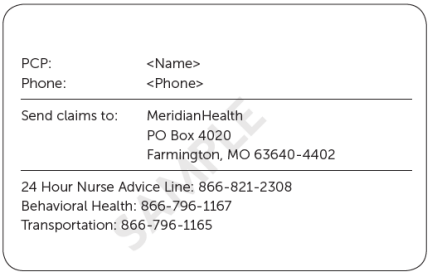
Member Services

Our Member Services department is available Monday through Friday, 7 a.m. to 5:30 p.m. for eligibility and benefit information and access to medical professionals. Have your Illinois Medicaid ID number ready when you call. You can call toll-free at **866-821-2308** to obtain benefit and eligibility information or to be connected to medical professionals. For medical advice, Meridian will connect you to our Nurse Advice Line, which offers medical guidance and support from a nurse. This phone line is for NOT for emergency situations. For emergency medical attention, please call 911.

Identification Card (ID Card)

You will have at least two ID cards: your MeridianHealth ID card and your Illinois Medicaid card. You should always carry your card with you. It has important phone numbers. You will need to show it when you get services. Your Meridian ID card will look like this:



Important ID Notes

- Bring both ID cards with you when you go to the provider.
- Do not let anyone else use your cards.
- You may also need to show a picture ID. This is to make sure the right person is using the card.
- If your name changes, call your caseworker to change your records.
- Please call Member Services at **866-821-2308** if you do not have your MeridianHealth ID card yet.

Open Enrollment

You can change your health plan during the first 90 days of enrollment. This period is called the "Initial Enrollment Period."

You are able to change health plans during a specific time once a year after the Initial Enrollment Period. This period is called “Open Enrollment.” Illinois Client Enrollment Services (CES) will send you an open enrollment letter about 60 days before your anniversary date. Your anniversary date is 1 year from your health plan start date. You will have 60 days during open enrollment to make a plan switch by calling CES at **877-912-8880**. After the 60 days has ended, whether you switch plans or not, you will be locked in for 12 months. Please contact CES at **877-912-8880** if you have questions about your enrollment or disenrollment with Meridian.

Disenrollment

You can change your health plan one time during the first 90 days. After that, you cannot change health plans for 1 year. Once each year, you can change health plans during the time called “open enrollment.”

You can opt out of MLTSS at any time if you choose to enroll in a Medicare-Medicaid Alignment Initiative (MMAI) plan.

Interpreter Services and Alternative Formats

Meridian can arrange for an interpreter to help you speak with us or your healthcare provider in any language. Interpreter services and alternative formats, including TTY (**711**), are provided to Meridian members free of charge. Alternative formats help members with different reading skills, backgrounds or disabilities understand Meridian materials. Please call if you need the Member Handbook or other materials in alternative formats.

¿Habla español?
Por favor contacte a Meridian al **866-821-2308**

Hearing and Vision Impairment

- We offer TTY service free of charge for those with hearing problems

- The TTY line is open 24 hours a day, 7 days a week at **711**
- We offer the Member Handbook and other materials in Braille for those with vision problems.
- Our website also has buttons to make the print bigger and simpler to read. You can also call for help.

Transportation

Meridian members have options for transportation to and from visits for covered services, pharmacies and durable medical equipment (DME) vendors. You can also get paid back for gas that is used to go to and from office visits. Please call **866-796-1165** at least 3 days before your appointment to talk about your transportation options.

When you call to arrange for transportation, please have ready:

- Your name, Medicaid ID number and date of birth
- The address and phone number where you will be picked up
- The address and phone number where you are going
- Your appointment date and time
- The name of your provider

Please call **866-796-1165** to learn more about your transportation options or to cancel your ride.

Away from Home

If you are away from home and need medical care, please take these steps:

- If it is not an emergency, call your PCP to talk about your illness or concern.
- If it is an emergency, go to the nearest emergency room or call 911.

Provider Directory

You can find the Provider Directory on our website at **https://findaprovider.ilmeridian.com**

The Provider Directory lists:

- Providers
- Office hours

- Board certifications
- Professional qualifications
- Addresses
- Office accessibility
- Languages spoken

Any relevant board certification can be found on our online Provider Directory. When you need to see a provider, call the office for an appointment.
Remember: Member Services can help you make an appointment for covered services.

Indian Tribe, Tribal Organization or Urban Indian Organization Providers
As an American Indian/Alaskan Native member, you have the right to receive services from an Indian Tribe, Tribal Organization or Urban Indian Organization provider in and outside of the State of Illinois. If you need help finding or changing your PCP, contact Member Services or your Care Coordinator at **866-821-2308**.

Primary Care Provider (PCP)

Your Primary Care Provider (PCP) is your personal provider who will give you most of your care. He or she may also send you to other providers if you need special care. You are able to pick your PCP. You can have one PCP for your whole family or you can choose a PCP for each family member.

Your PCP will act as your health home, tracking your health records, referring specialists and offering medical advice, all with an active understanding of your health needs. He or she will assist you in preventing illness and promoting health. You may see your PCP in a private practice setting or at a clinic, such as a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
You can choose one of these providers as your PCP:

- General provider
- Family provider
- Nurse practitioner (nurse with special training)
- Physician assistant (supervised by a provider)
- Internist (provider for adults)
- Pediatrician (provider for children/teens)

- OB-GYN (provider for women)
- FQHC or RHC
- Or other specialists based on medical necessity

PCP services may include:

- Routine physical exams
- Diagnostic tests
- X-rays and lab tests
- Immunizations
- Allergy treatment and tests
- Wellness services

PCP Telephone Access
You can call your PCP 24 hours a day, 7 days a week. Call Meridian at **866-821-2308** if your PCP does not call you back.

How to Change PCP

Meridian wants you to be happy with your PCP. You can change your PCP at any time. You can do this on Meridian's Member Portal at **member.ilmeridian.com**. You can also contact Member Services or your Care Coordinator at **866-821-2308** and they can help you with changing your PCP.

Second Opinions

You have the right to a second opinion at no cost, whether from a Meridian provider or not. If you need help getting a second opinion, call Member Services at **866-821-2308**.

Benefits

A Summary of Your Benefits

No matter how you receive health insurance, it is important you understand the benefits covered under your plan. As a MeridianHealth member, you DO NOT have to pay co-pays for covered services. Please be sure to find a provider in Meridian's network that you work well with and can meet your needs. If you try to use a provider outside of MeridianHealth's network, a prior authorization must be submitted by your provider before you receive services. Please call **866-821-2308** if you need help finding a provider.

Below is a summary of services covered under your health plan with Meridian. To find a complete list of covered services, please refer to your Certificate of Coverage (COC). Please call Member Services at **866-821-2308** if you would like a printed copy of the COC.

Services Covered by Meridian

This grid lists services covered by Meridian. Your Certificate of Coverage (COC) has a complete list of covered services. If you would like a printed copy of the COC, please call Member Services at **866-821-2308**. Call Meridian if you need help finding a Meridian provider for a service you need. If there is not a provider in our network to deliver the service, you may see an out-of-network provider but you must get an approval first. Below are the available services that are covered out of network without a referral. **NOTE: Meridian members DO NOT have co-pays for covered services.**

Covered Services for MLTSS Members

Covered Services	
Waiver Services	See details in Waiver Benefits section. • Agency Providers RN, LPN, CNA and Therapies • Individual Providers PA, RN, LPN, CNA and Therapies
Long Term Care	• Skilled • Intermediate

	• Nursing Facility Benefit
Behavioral Health	Behavioral health services are a type of healthcare that offers emotional support, treatment, counseling and guidance. Meridian covers behavioral health (BH) services without a referral in partnership with DHS Mental Health Rehab Option Services. Our BH staff can help you get the services you need. Please call us at **866-796-1167**. We can help you find a provider and make an appointment. All services are confidential. • Mental Health Rehab Option Services • Alcohol and Substance Abuse Rehabilitation Services • Outpatient Behavioral Healthcare
Transportation	Many transportation options are available to and from office visits, behavioral health appointments, pharmacies, DME vendors, Family Case Management and WIC offices. Please call **866-796-1165** to talk about your transportation options. • Non-Emergency Ambulance Transportation • Medical Transportation • Additional Transportation Services (including Taxicab, Service Car, Private Auto and Other)
Other Benefits	• Over-the-counter benefit: $10 per month. See section on Over-the-Counter (OTC) Drugs • Nurse Advice Line

Waiver Benefits

Members are allowed to receive additional benefits once they receive a waiver for services. These waivers offer long-term services and supports for individuals who need extra help with daily activities but do not wish to enter a nursing home. An individual interested in receiving waiver benefits must be approved for a waiver by the Illinois Department on Aging or Department of Rehabilitation Services (DRS) before receiving services. MeridianHealth coordinates member benefits for five Medicaid waivers offered by the state departments:

- Elderly Waiver
- Person with Disabilities Waiver
- HIV/AIDS Waiver

- Traumatic Brain Injury Waiver
- Supportive Living Facility (SLF) Waiver

Not all waivers receive the same benefits. Below is a list of benefits that apply to waivers. If you currently have a waiver benefit, please proceed to the Waiver Services Grid to determine if a service applies to your waiver.

Long Term Services & Supports (Dependent on Waiver Eligibility)	
Adaptive Equipment	Devices, controls or appliances, specified in the plan of care, to improve ability to perform activities of daily living.
Adult Day Service	Community-based social services offering a variety of social, recreational, health, nutrition and related supports in a communal setting during daytime hours.
Assisted Living	Apartment-style housing with the following menu of services: • Intermittent nursing services • Meals and snacks • Medication oversight • Personal care • Well-being check • Social/recreational programming • Health promotion and exercise programming • Maintenance • 24-hour response/security staff • Emergency call system • Laundry • Housekeeping • Ancillary services
Personal Emergency Response System	Electronic equipment, linked to a telephone line, providing 24-hour access to help in an emergency.
Environmental Accessibility Adaptions	Physical modifications to the home setting in order to support individual health, welfare and safety needs. (Adaptions intended for some other purpose not included.)
Home-Delivered Meals	Meal services consisting of home-delivered meals for lunch and/or dinner service.

Nursing — Skilled	Nursing services for short-term acute healing needs. Intended as an alternative to hospitalization or nursing facility stay.
Nursing — Intermediate	Long-term nursing services to provide medical expertise in the home to assist in the treatment of chronic conditions.
Home Health Aide	In-home help with basic health needs under supervision of medical professional.
Homemaker	In-home caregiver providing help with activities of daily living such as meal preparation, shopping, light housekeeping and laundry.
Personal Assistant	In-home caregiver hired directly by a member to provide help with activities of daily living such as meal preparation, shopping, light housekeeping and laundry. (These can include direct caregivers such as RNs, LPNs, and Home Health Aides.)
Rehabilitation Services	Physical, Occupational and Speech Therapy services covered with waiver.
Respite	Caregiver services intended to relieve unpaid family members who are assisting member.
Supported Employment	Services intended to allow member to remain in the workforce, including supervision and training.
Supportive Living Facility	Assisted living residence providing support services to meet members needs to remain independent, including: housekeeping, personal care, medication oversight, shopping, meals and social programs.
Day Habilitation	Independent living skills, including self-help management, socialization and building adaptiveness. Intended to help member gain maximum functional level.
Prevocation Services	Work training designed to help skill-building to join the general workforce. Includes attendance, task completion, problem-solving and safety.

Benefits by Waiver Type

Service	Elderly	Disabled	HIV/AIDS	Brain Injury	SLF Waiver

Adult day service	X	X	X	X	
Adult day service transportation	X	X	X	X	
Assisted living					X
Environmental modification		X	X	X	
Supported employment				X	
Home health aide		X	X	X	
Nursing: Intermittent		X	X	X	
Nursing: Skilled		X	X	X	
Occupational therapy		X	X	X	
Personal assistant		X	X	X	
Physical therapy		X	X	X	
Speech therapy		X	X	X	
Service	**Elderly**	**Disabled**	**HIV/AIDS**	**Brain Injury**	**SLF Waiver**
Prevocational services				X	
Day habilitation				X	
Homemaker	X	X	X	X	
Home delivered meals		X	X	X	
Emergency home response system	X	X	X	X	
Respite		X	X	X	
Specialized medical equipment/supplies		X	X	X	
Behavioral services				X	

All services require prior authorization. Existing care plan service will not require authorization for first 90 days.

Over-the-Counter (OTC) Drugs
You receive a fixed dollar amount each month to spend on eligible OTC products that you use for medical purposes. Only you can use your benefit. OTC drugs and products are intended for your use only. You can order up to $10 of eligible OTC items each month from our OTC catalog. Any unused amount does not carry over to the next month. We will not reimburse you for purchased OTC items. Prescription drugs are not covered under the MLTSS program. To get prescription drugs, contact your Medicare/Medicaid plan to learn what is available to you.

Non-Covered Services by Meridian MLTSS or Illinois Healthcare and Family Services (HFS)

This is not a complete list:

- Any service that is not approved by your PCP, except the following:
    - Emergency care, well-woman care, maternity care, behavioral health care, services at local health departments, immunizations, family planning, pediatrician visits or as required by HFS or otherwise stated in this handbook
- Elective cosmetic surgery
- Experimental and/or investigational drugs, procedures or equipment
- Infertility care and medicine for erectile dysfunction
- Services provided in an Intermediate Care Facility for the developmentally disabled
- Services provided through Local Education Agencies
- Any service that is not medically necessary
- Hospice*
- Surgery
- Outpatient care
- Emergency and urgent care/hospital services
- Family planning, birth control, obstetric and maternity care, sterilization, abortions
- Physician services
- Dental services
- Optometric services

- Podiatric services
- Chiropractic services
- Physicians psychiatric services
- Development therapy, orientation and mobility services (waivers)
- DSCC counseling/fragile children
- DCFS rehab option Services
- PT/OT/ST services
- Audiology services
- Anesthesia services
- Midwife services
- Genetic Counseling
- General clinic services
- Inpatient psychiatric clinic services
- Clinic services (physical rehabilitation)
- Mental health clinic option services
- Pharmacy services
- Clinical laboratory services
- Portable X-ray services
- Optical supplies
- Medical supplies
- Emergency ambulance transportation
- Nurse practitioners services
- Social work service
- Psychologist service
- Subacute care program
- SOPF-MI
- LTC-developmental training (levels I-III)
- LTC-MR recipient between ages 21-65; inappropriately placed
- Transplants
- Genetic counseling
- Medical equipment/prosthetic devices
- LTC-NF skilled (partial Medicare coverage)

* If you live in a nursing home and need hospice care, Meridian will cover room and board for that care.

MLTSS members will receive Medicare-covered services such as hospitalization, provider visits, therapies, prescriptions, laboratory and X-ray services, medical supplies and more through Medicare fee-for-service, Medicare Part D or Medicare Advantage. Please contact the Social Security Administration at **800-772-1213** for more information.

Prior Authorization

We cover most care without a referral or medical review. However, some care needs a prior authorization (PA). Your provider has a list of care that needs PA. Your provider needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. Note: We must approve the PA request before you can get the care.

Some benefits require PA before receiving services. PAs may be required for services like:

- Non-emergent transportation
- DME products
- Services provided by out-of-network providers

If this is the case, your provider needs to fill out a Prior Authorization Request Form and send it to MeridianHealth. Meridian reviews the request to ensure the service is medically appropriate and necessary. Once Meridian authorizes the service, you may receive it.

Nurse Advice Line

A toll-free nurse advice line is available to members 24 hours a day, 7 days a week. You can get medical guidance and support from a nurse by calling **866-821-2308** and asking to be transferred to the nurse advice line. For life-threatening emergencies, you should call 911 or local emergency services.

Moving?

Don't forget to call your local HFS office and
Meridian Member Services with your new address.

To find your local HFS office, go to **www.dhs.state.il.us**

and click on “DHS Office Locator” under the “about DHS” section.

Meridian Member Services: **866-821-2308**

Member Committees
Meridian hosts committees throughout the year to hear feedback from members on the quality of care they are being provided, input on educational materials and program information. Member feedback is needed to properly address any needs or issues with your care.

To learn more about these meetings and tell us if you're interested in participating, please contact Member Services at **866-821-2308**.

Special Healthcare Programs

Care Coordination

It’s easy to feel overwhelmed with your health care and coordinating several providers or health issues. It can add more stress to your daily life.

Meridian is here to help you!
Our goal is to offer personal care for you and to help make your quality of life better. We have nurses, care coordinators, social workers and other healthcare experts to help you and your care team navigate the system. You are assigned a Care Coordinator who will visit you regularly in a location that is best for you.

What is Care Coordination?
Care Coordination is a program that links you to services and resources in your community that will help improve your health while arranging care with your care team and providers. This program is focused on you and your needs in order to best help you navigate your healthcare team.

The goals of Care Coordination are to:

- Focus on your personal needs
- Help you access community resources and services
- Work with your PCP to arrange care and make sure you are taking care of your health as planned
- Work with you, your authorized representative or your guardian to help

you determine your needs and services to meet those needs

How can Care Coordination help you?
Your Care Coordinator will:

- Make a plan of care to meet your healthcare goals
- Connect you with resources in your community
- Help you control your health issues or conditions
- Help you understand your coverage through MeridianHealth
- Answer your questions or concerns
- Ask questions to learn more about you. He or she will ask about your strengths, what you can do and what you need help with
- Work with you and your authorized representative as you decide on services to meet your needs
- Help to approve your long-term care stay if you live in a nursing facility
- Help get the services you need based on your waiver program if you live in the community
- Assist you as long as you are a Meridian member and in a nursing facility or HCBS waiver program
- Visit you in your home at different frequencies based on your need
- Visit you at least once every three months if you are in the Persons with an Elderly Waiver or the Persons with a Disabilities Waiver
- Contact you at least once every month if you are in the Persons with a Brain Injury Waiver
- Contact you at least monthly by phone and visit you at least every other month if you are in the Persons with a HIV/AIDS Waiver
- Help to complete an assessment visit and service plan with you every year if you live in your own home or in a supportive living setting
- Help to complete an assessment visit and service plan with you every 6 months if you live in a nursing facility
- Visit you more if your needs change

Population Health Management Program

Program Name	Description
Smoking Cessation Program	Meridian offers a Smoking Cessation Program to help members stop smoking. Call Meridian to learn more about this program.

Please speak to your provider or call Member Services at **866-821-2308** for more information.

Disease/Health Education Management Program

Another Special Care Program is the Disease Management Program to help our members with chronic conditions such as cardiovascular disease (CVD) (heart problems), diabetes, asthma and other chronic conditions. The Disease Management Program allows members to access support from nurses and healthcare staff and educational materials to help you learn how to manage your condition. If you have asthma, attention deficit hyperactivity disorder, cardiovascular disease, chronic obstructive pulmonary disease, congestive heart failure, depression, anxiety, substance abuse disorder, diabetes or hypertension, you may be signed up automatically by Meridian. You can also sign up for the program by calling **866-821-2308** or your provider can sign you up.

Away from Home

If you are away from home and need medical care, please take these steps:

- If it is not an emergency, call your PCP to talk about your illness or concern
- If it is an emergency, go to the nearest emergency room or call 911

Post-stabilization Care

Post-stabilization services are needed services given to a member once the member is stabilized following an emergency medical condition to make the member better. Post-stabilization gives members the chance to keep up the stabilized condition or to improve or resolve the member's condition. Once a member has been treated and is in stable condition, services become post-stabilization services. Post-stabilization services are covered and do not require prior authorization.

After you go to the emergency room, you should call your PCP within 24 hours. Your PCP will make sure you get the follow-up care you need. You can call your PCP 24 hours a day, 7 days a week. Your PCP can help you decide if you need

emergency care. If your PCP does not call you back, call Meridian at **866-821-2308**.

Cultural Competency

Cultural competency is a set of attitudes, behaviors and policies that help people work with others whose ideas and beliefs are different from their own. Meridian is dedicated to the goal of educating our employees and partners on cultural competency to help provide the best health care for our members. Meridian hosts focus groups that discuss your care, feedback and our cultural competency that are open to member participation. If you are interested in attending one of these workgroup meetings, please call Member Services.

Advance Directives

An advance directive is a written decision you make about your future health care in case you are so sick you can't make a decision at that time. In Illinois, there are four types of advance directives:

1. Healthcare Power of Attorney
This lets you pick someone to make your healthcare decisions if you are too sick to decide for yourself. The person you pick should be someone you trust, like a family member or a friend. The person you pick will be able to:

- See your medical information and other personal information
- Choose and dismiss your healthcare providers
- Say yes or no to medical treatment
- Sign waivers and other documents to allow or stop your medical care

Talk with your healthcare power of attorney about your values and wishes. The more this person knows about you, the better decisions he or she can make.

2. Living Will
This document tells your provider and other providers what type of care you want if you are terminally ill, which means you will not get better. You can accept or refuse any care. Your Living Will becomes active ONLY when you are not able to make decisions on your own.

3. Mental Health Preference
This lets you decide if you want to receive some types of mental health treatments that might be able to help you.

4. Do Not Resuscitate (DNR) order
This tells your family and providers what you want to do in case your heart or breathing stops.

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

You Get a Bill or Statement
MeridianHealth does not charge co-pays or have deductibles for its members. This means that you should never get any bills for your Meridian-covered benefits or pre-authorized services. If you receive a bill by mistake, send it to the address below:

MeridianHealth
Attn: Claims Department
PO Box 4020
Farmington, MO 63640-4402

If you have any other problems with medical bills for Meridian-covered services, please call Member Services at **866-821-2308** for help.

Sometimes you may get a bill for services you received before you joined Meridian. For this type of bill, please call your provider's office for help.

Grievances and Appeals

We want you to be happy with services you get from Meridian 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 **866-821-2308**.

Meridian 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 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 resolve your concern. Filing a grievance will not affect your healthcare 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 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 staff member was rude to you
- Your provider or a Meridian staff member was insensitive to your cultural needs or other special needs you may have

You can file your grievance on the phone by calling Member Services at **866-821-2308**. You can also file your grievance in writing via mail or fax at:

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244
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 **866-821-2308**.

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 hard of hearing, call the Illinois Relay at **711**.

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

We will acknowledge your grievance by sending you or your representative a letter within 48 hours of receiving the grievance. The resolution time frame for a grievance can take up to 90 calendar days.

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 an "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 to ask for an expedited appeal in some circumstances 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 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 the provider was not in our network

Here are two ways to file an appeal.

1) Call Member Services at **866-821-2308**. If you file an appeal over the phone, you must follow it with a written and signed appeal request.
2) Mail or fax your written appeal request to:

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244
Fax: **833-669-1734**

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 hard of hearing, call the Illinois Relay at **711**.

Can someone help you with the appeal process?
You have several options for help. You may:

- Ask someone you know to help represent you. This could be your primary care provider or a family member
- 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 his or her contact information in the letter or, 2) fill out the Authorized Representative Appeals form. You will find this form on our website at **ilmeridian.com**.

Appeal Process

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

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

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

If 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 's decision does not agree with the Adverse Benefit Determination , we will approve the services to start right away.

Things to keep in mind during the appeal process:

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

How can you expedite your appeal?

If you or your provider believes our standard time frame of fifteen (15) business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, 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 at **866-821-2308**.

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

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

At the State Fair Hearing, just like during the Meridian 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.gov
Or you may call (855) 418-4421, TTY: (800) 526-5812

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

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-8573
Email: DHS.HSPAppeals@illinois.gov
Or you may call (800) 435-0774, TTY: (877) 734-7429

State Fair Hearing Process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time and place of the hearing.

This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at 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 (3) business days before the hearing, you will receive information from Meridian. 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 and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

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

Failure to Appear at the Hearing
Your appeal will be dismissed if you or your authorized representative do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted by phone, your appeal will be dismissed if you do not answer your phone 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, 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. 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:**

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244

What happens next?

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

- You have **five (5) business days** from the letter we send you to send any additional information about your request to the external reviewer.

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

Expedited External Review

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an **expedited external review.** You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at **866-821-2308**. 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.

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244
Fax: 833-669-1734

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 he or she can begin the review.
- As quickly as your health condition requires, but no more than two 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 know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Meridian with a decision within fourty-eight (48) hours.

Other Important Information

How Meridian Makes Healthcare Decisions

Meridian providers and healthcare staff make decisions based on the care that is right for you and what is covered by your Medicaid benefits. This is called Utilization Management (UM).

Meridian does not reward providers for denying you care. Meridian employees who make UM decisions are not rewarded for limiting your care.

You can call Meridian at any time if you have a question about your benefits, providers or any service you have asked for or received. You can call Member Services at **866-821-2308**. We are open Monday through Friday, 7 a.m. to 5:30 p.m. When a Meridian representative answers the phone, he or she will greet you by telling you his or her name, title and company. All calls you make are toll-free.

New Technology

Meridian wants to make sure our members have access to new health technologies and procedures. Members can recommend Meridian cover new technology. Meridian providers and clinical staff research new technology before it is approved for our members. Any updates that affect members will be communicated through the member newsletter.

This information comes from medical professional groups, Medicaid, other government groups and scientific groups.

Rights and Responsibilities

As a Meridian member, you have rights and responsibilities. We believe you should always be treated with dignity and respect. Meridian staff will comply with all requirements concerning these rights. Meridian will not discriminate against you for exercising your rights.

Your rights:

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

Your responsibilities:

- Treat your provider and the office staff with courtesy and respect
- Carry your Meridian ID card with you when you go to your provider appointments and to the pharmacy to pick up your prescriptions
- Keep your appointments and be on time for them
- If you cannot keep your appointments cancel them in advance
- Follow the instructions and treatment plan you get from your provider
- Tell your health plan and your caseworker if your address or phone number changes

- Read your member handbook so you know what services are covered and if there are any special rules

Please call Member Services at **866-821-2308** if you have any questions.

Fraud, Abuse and Neglect

Fraud, Abuse and Neglect are all incidents that need to be reported.

You must report any members, providers or pharmacies who commit fraud. You do not have to give your name to report it. You can report fraud to the Fraud, Waste & Abuse Hotline at: **866-685-8664** or email: **Special_Investigations_Unit@CENTENE.COM**.

Fraud occurs when someone receives benefits or payments he or she is not entitled to. Some other examples of fraud are:

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

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

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

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

Exploitation is when someone deprives, defrauds or otherwise takes money or personal property in an unfair or cruel way, against one's will or without consent or knowledge for his or her own benefit.

Reporting Abuse, Neglect, Exploitation or Unusual Incidents
If you believe you are a victim, you should report this right away. You can call your Care Coordinator or Member Services at **866-821-2308**. Meridian must follow up with you to provide resources and ensure your safety.

If you are the victim of abuse, neglect or exploitation, you should report this to your Meridian Case Manager right away. You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept confidential. Anonymous reports are accepted.

The Health Care Worker Background Check Act applies to all unlicensed individuals employed or retained by a healthcare employer as home healthcare aides, nurse aides, personal care assistants, private duty nurse aides, day training personnel or an individual working in any similar health-related occupation where he or she provides direct care. You can contact the Department of Public Health online at **www.dph.illinois.gov** or by phone at **217-785-5133** to verify status prior to employment, or the Department of Financial and Professional Regulation for information on any Licensed Practical Nurse (LPN) or Registered Nurse (RN) (nurses) that you want to employ to see if they have allegations of abuse, neglect or theft.

Nursing Home Hotline: 800-252-4343
Illinois Department of Public Health Nursing Home Hotline is for reporting complaints about hospitals, nursing facilities and home health agencies and the care or lack of care of the patients.

Supportive Living Program Complaint Hotline: 844-528-8444

Adult Protective Services: 866-800-1409 (TDD/TTY: 888-206-1327)
The Illinois Department on Aging (IDOA) Adult Protective Services Hotline is for reporting allegations of abuse, neglect or exploitation for all adults 18 years old and over. Your Meridian Case Manager will provide you with two brochures on reporting Abuse, Neglect and Exploitation. You can request new copies of these brochures at any time.

Definitions

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

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

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

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

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

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

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

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

Home Health Care means healthcare services a person receives at home.

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

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

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

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

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

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

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

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

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

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

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

Urgent Care means care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Summary of Privacy Practices

This summary describes how personal and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you would like the full Notice of Privacy Practices, please visit **ilmeridian.com** or call Member Services at **866-821-2308** for a printed copy.

INFORMATION WE HAVE. We have enrollment information about you which includes your date of birth, sex, identification number and other personal information. We also receive bills, physician reports and other information about your medical care.

OUR PRIVACY POLICY. We care about your privacy and we guard your information carefully whether it is in oral, written or electronic form. We are required by law to maintain the privacy of that information and to provide you with this notice of our legal duties and our privacy practices. We will not sell any information about you. Only people who have both the need and the legal right may see your information. Unless you give us a written authorization, we will only disclose your information for purposes of treatment, payment, business operations or when we are required by law to do so.

TREATMENT. We may disclose medical information about you for the purpose of coordinating your health care. For example, we may notify your Primary Care Provider about treatment you receive in an emergency room.

PAYMENT. We may use and disclose medical information about you so that the medical services you receive can be properly billed and paid for. For example, we may ask a hospital emergency department for details about your treatment before we pay the bill for your care.

BUSINESS OPERATIONS. We may need to use and disclose medical information about you in connection with our business operations. For example, we may use medical information about you to review the quality of services you receive.

AS REQUIRED BY LAW. We will release information about you when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

AUTHORIZATIONS. We may use and disclose your personal information if you give us a written authorization to do so. If you give us a written authorization, you have the right to change your mind and revoke that authorization.

COPIES OF THIS NOTICE. You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy.

CHANGES TO THIS NOTICE. We reserve the right to revise this Privacy Notice. A revised notice will be effective for information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published in our member newsletter.

YOUR RIGHT TO INSPECT AND COPY. You may request, in writing, the right to inspect the information we have about you and to get copies of that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

YOUR RIGHT TO AMEND. If you feel that the information we have about you is incorrect or incomplete, you can make a written request to us to amend that information. We can deny your request for certain limited reasons, but we must give you a written reason for our denial.

YOUR RIGHT TO A LIST OF DISCLOSURES. Upon written request, you have a right to receive a list of our disclosures of your information, except when you have authorized those disclosures or if the disclosures are made for treatment, payment or healthcare operations. We are not required to give you a list of disclosures made before April 14, 2003.

YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE OR DISCLOSURE OF INFORMATION. If you do so in writing, you have the right to request restrictions on the information we may use or disclose about you. We are not required to agree to such requests.

YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. For example, you can ask that we only contact you at home or only at a certain address or only by mail.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE. If you want to use your rights under this notice, you may call us or write to us. Your request to us must be in writing. We will help you prepare your written request, if needed.

COMPLAINTS TO THE FEDERAL GOVERNMENT. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Room 509F HHH Bldg.
Washington, D.C. 20201

or visit their website at **www.hhs.gov/ocr**. You will not be penalized for filing a complaint with the federal government.

QUESTIONS OR COMPLAINTS ABOUT PRIVACY AND COMMUNICATIONS TO US. If you want to exercise your rights under this Notice, if you wish to communicate with us about privacy issues or if you wish to file a privacy-related complaint, you can write to:

MeridianHealth
Privacy Officer
300 S. Riverside Plaza, Suite 500
Chicago, IL 60606

You can also call us as at **866-821-2308**. You will not be penalized for filing a complaint. You can view a copy of this notice on our website at **ilmeridian.com**.

Disclaimers

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

MeridianHealth:

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

If you need these services, contact Meridian's Grievance Coordinator. If you believe that MeridianHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Meridian's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Meridian's Grievance Coordinator is available to help you.

Mail: MeridianHealth
Attn: Grievance Coordinator
PO Box 44287
Detroit, MI 48244
Telephone: 866-821-2308, (TTY users should call 711)
Fax: 833-669-1734
Email: medicaidgrievances@mhplan.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil

Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-821-2308 (TTY: 711).

Polski (Polish): UWAGA:Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 866-821-2308 (TTY: 711).

繁體中文 **(Chinese):** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866-821-2308 (TTY: 711)。

한국어**(Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866-821-2308 (TTY**:** 711)번으로 전화해 주십시오.

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 866-821-2308 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 866-821-2308 (رقم هاتف الصم والبكم: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866-821-2308 (телетайп: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 866-821-2308 (TTY: 711).

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی دستیاب میں مفت خدمات کی ہیں۔ کریں کال 866-821-2308 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 866-821-2308 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 866-821-2308 (TTY: 711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 866-821-2308 (TTY: 711) पर कॉल करें।

Français (French): ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposes gratuitement. Appelez le 866-821-2308 (ATS : 711).

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 866-821-2308 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 866-821-2308 (TTY: 711).

Need Help?

Call Member Services: **866-821-2308**.

We're open Monday through Friday, 7 a.m. to 5:30 p.m..

Visit the Meridian website at **ilmeridian.com**

Log in to My MHP (Member Portal)
Open only to our members, My MHP is an easy, secure way to handle your health information. You can use My MHP to:

- Get a replacement ID card
- Change your address or phone number
- Request a Member Handbook
- Find Behavioral Health specialist providers and other specialists in your area
- You can sign up for My MHP online at **member.ilmeridian.com**

You can also call Member Services at **866-821-2308** for help. You will need your Medicaid ID number to sign up.

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State Approved: 2021/03/31

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