meridianhealth

Department of Healthcare & Family Services
HealthChoice Illinois
Your Health. Your Choice.

Illinois *member* handbook.

Effective date: July 1, 2021
Member services: 866-606-3700
TTY/TDD: 711

ILmeridian.com

Welcome to MeridianHealth

Intro to Plan

Thank you for choosing MeridianHealth (Meridian). We are here to give quality healthcare to you and your family.

Meridian covers a wide range of services and benefits. This handbook will help you understand your coverage. It will help you get the care you need.

We want you to be happy with your healthcare services. If you have any questions, call Meridian Member Services toll-free at **866-606-3700**.

Important Phone Numbers & Contacts

In an Emergency	911
Meridian Member Services	866-606-3700
TTY for the Hearing Impaired	711
Website	ilmeridian.com
Transportation (non-emergency)	866-796-1165
Behavioral Health Services	866-796-1167
Pharmacy Services Team	855-580-1688
Illinois Client Enrollment Services (CES)	877-912-8880 (TTY: 866-565-8576)
Women, Infants and Children (WIC)	217-782-2166
Nurse Advice Line (24 hour)	866-606-3700

Service Area

Meridian covers all counties in the State of Illinois.

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.
Call Member Services at **866-606-3700**.

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Member Services

Welcome to Meridian!

Our Member Services department is ready to help you get the most from Meridian. You can call Member Services toll-free at **866-606-3700** Monday through Friday, 7 a.m. to 5:30 p.m. to help if you need:

- More information about your benefits
- To find a primary care provider (PCP)
- To change your PCP
- To get basic plan information
- A new Meridian ID card or handbook
- To change your address or phone number
- To file a complaint

Have your Illinois Medicaid ID number ready when you call.

Our Member Services department provides eligibility and benefit information and access to medical professionals. You can call toll-free at **866-606-3700** to get benefit and eligibility information or to get 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.

Member Identification (ID) Card

You will receive a Member ID Card. You should always carry your card with you. It has important phone numbers. You will need to show it when you get services.

Information on your Member ID Card:

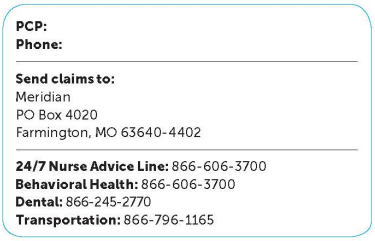
- Name
- Plan name
- State Medicaid ID #
- PCP information (name, phone number)
- Effective date
- Member Services phone #
- 24-hour Nurse Advice Line
- Behavioral Health phone #
- Dental phone #
- Transportation phone #
- Prescription coverage information for providers
- Name & address of Meridian
- Providers can send claims via electronic data interchange (EDI) or online using our secure provider portal


meridian

300 South Riverside Plaza
Suite 500
Chicago, IL 60606

Member Name:
Plan Name: HealthChoice Illinois
Medicaid ID:
Effective Date:
Member Services: 866-606-3700 (TTY: 711)

RxBIN: 004336
RxPCN: MCAIDADV
Group: RX5491
Pharmacy Help Desk: 888-624-1145


PCP:
Phone:

Send claims to:
Meridian
PO Box 4020
Farmington, MO 63640-4402

24/7 Nurse Advice Line: 866-606-3700
Behavioral Health: 866-606-3700
Dental: 866-245-2770
Transportation: 866-796-1165

Open Enrollment

Once each year, you can change health plans during a specific time called "Open Enrollment." Client Enrollment Services (CES) will send you an open enrollment letter approximately 60 days prior to your anniversary date. Your anniversary date is one year from your health plan start date. You will have 60 days during your open enrollment to make a one plan switch by calling CES at **877-912-8880**. After the 60 days has ended, whether a plan switch was made or not, you will be locked in for 12 months. If you have questions regarding your enrollment or disenrollment with Meridian please contact the Client Enrollment Service (CES) at **877-912-8880** (TTY: **866-565-8576**).

Provider Network

A Provider Network is a list of the providers, specialists, hospitals and other providers that Meridian has contracted with to provide your care. Meridian's Provider Directory lists providers in Meridian's network. Meridian's directory also lists:

- PCPs
- Addresses
- Office hours
- Board certifications
- Professional qualifications
- Medical school attended
- Residency
- Board certification status
- Languages spoken
- Specialists
- Hospitals
- Pharmacies
- Other healthcare support

You can find the Provider Directory on our website at **https://findaprovider.ilmeridian.com**. Please call Member Services if you would like a printed copy of the Provider Directory. Member Services can also help you find a provider who speaks your preferred language. You can use Meridian's directory as an added resource to find the language(s) spoken by a provider. You can call Meridian Member Services while with your provider and speak with a representative in your preferred language for any of your healthcare needs.

You must go to providers in Meridian's network. 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. Call Member Services at **866-606-3700** to get help with an approval. Meridian must adequately cover these out-of-network services in a timely manner, as long as Meridian is able to provide them and ensure that the cost is no greater than it would be if the service was provided in-network.

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. With Meridian, you can 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 help you prevent illness and promote 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
- Other specialists based on medical necessity

PCP services may include:

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

If you are an American Indian/Alaskan Native member, you have the right to get 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 **866-606-3700**.

How to Change PCP

You can change your PCP at any time. Please contact Member Services at **866-606-3700**, Monday through Friday, 7 a.m. to 5:30 p.m., or visit Meridian's Member Portal at **member.ilmeridian.com**.

Women's Healthcare Provider (WHCP)

As a woman with Meridian coverage, you have the right to select a Women's Healthcare Provider (WHCP). A WHCP is a provider licensed to practice medicine specializing in obstetrics, gynecology or family medicine.

Prenatal and Postpartum Rewards

Meridian wants to make sure you and your baby stay healthy. Prenatal and Postpartum Rewards is a program that helps expecting moms schedule prenatal and postpartum appointments, arrange transportation for prenatal and postpartum appointments and win prizes like a gift card or baby gear. We will contact you with information and let you know what prizes you are eligible for.

How to Enroll Your Newborn

When you have a baby, call CES at 877-912-8880. CES will add your baby to your case. This is the first step to sign your baby up for Meridian. When you have a baby, the baby is covered by Meridian at the time of birth. You need to call Member Services at **866-606-3700** and tell us the day you gave birth, the baby's name and the baby's Medicaid ID number you get from CES.

Members may stay in the hospital up to 72 hours after a normal vaginal delivery and up to 96 hours after a Cesarean delivery. Meridian works with the Family Case Management (FCM) Program to coordinate your care. See the Family Case Management section for more information.

Family Planning

Meridian has a network of Family Planning providers where you can get family planning services; however, you may choose to get family planning services and supplies from any out-of-network provider without a referral and it will be covered.

Specialty Care

A specialist is a provider who cares for you for a certain health condition. An example of a specialist is doctor who specializes in cardiology (heart health) or orthopedics (bones and joints). If your PCP thinks you need a specialist, he or she will work with you to choose a specialist. Your PCP will arrange your specialty care.

Referrals to in-network providers do not require prior authorization. Specialty referrals to an out-of-network provider require prior authorization.

You can use Meridian's online Provider Directory to find a list of specialists in your area at **https://findaprovider.ilmeridian.com**.

You can call Member Services at **866-606-3700** for more information. If you have a Care Coordinator, we can also help you find a specialist.

Scheduling Appointments

It is very important that you keep all appointments you make for provider visits, telehealth (virtual) visits, lab tests or X-rays. Please call your PCP at least one day ahead of time if you cannot keep an appointment. If you need help making an appointment, please contact Members Services at **866-606-3700**.

Member Committees

Meridian hosts committees throughout the year to hear feedback from members. We want to know about the quality of care members receive. We also ask for 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 **866-606-3700**.

Nurse Advice Line

The Nurse Advice Line is a free, confidential service where you can get health information from a nurse anytime you need it. You can reach the Nurse Advice Line by calling Meridian at **866-606-3700**. A nurse is available to all members 24 hours a day, 7 days a week. The goal is to help you get the right care, in the right place, at the right time.

The nurse you talk to will help you understand if you or a family member needs urgent medical care, if you can safely wait to see your provider or if your symptoms can be cared for at home.

Sometimes nurses can even give you tips to help you feel better faster. You can call from anywhere, at any time. Meridian encourages members to save the toll-free number into their cell phone for easy access.

Call the 24-hour Nurse Advice Line if you have:

- Fever, cough or sore throat
- Ear ache or headache
- Cold or flu
- Asthma, diabetes or other chronic conditions
- Back or joint pain
- A crying baby who might be sick
- An upset stomach or are vomiting
- Cuts, scrapes or minor burns
- Injuries from slips and falls
- Any other health concern

For life-threatening emergencies, call 911 or local emergency services.

Urgent Care

Urgent care is an issue that needs care right away but is not life threatening. Some examples of urgent care are:

- Minor cuts and scrapes
- Cold
- Fever
- Ear ache

Call your PCP for urgent care or call Meridian Member Services at **866-606-3700**. For anyone experiencing a mental health crisis, call the Behavioral Health Crisis Line at **800-345-9049** (available 24/7).

Emergency Care

An emergency medical condition is very serious. It could even be life-threatening. You could have severe pain, injury or illness. Some examples of an emergency are:

- Heart attack
- Difficulty in breathing
- Poisoning
- Severe bleeding
- Broken bones

What to do in case of an emergency:

- Go to the nearest Emergency Department; you can use any hospital or other setting to get emergency services
- Call 911
- Call an ambulance if there is no 911 service in area
- No referral is needed
- Prior authorization is not needed, but you should call us within 24 hours of your emergency care

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, in order 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.

Follow-Up Care after an Emergency Room Visit or Hospital Stay:

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 **866-606-3700**.

Covered Services

It is important you understand the benefits covered under your plan. As a Meridian Medicaid member, you do not have to pay co-pays for covered services. This is a list of care you can get with Meridian. Your Certificate of Coverage (COC) has the complete list of covered care. If you want a printed copy of the COC or have questions regarding your benefits, contact Member Services.

Prior Authorization

We cover most care without a referral or medical review. However, some care needs prior authorization (PA). Your provider has a list of care that needs PA. Your provider needs to fill out a PA 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. When a provider submits a PA form, one of our clinical staff reviews the request and decides if:

- It is medically necessary, which means that the healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms meet accepted standards of medicine
- You can get the care from a provider in our network

Seeking services out of network may require PA. All out-of-state services require prior authorization.

Covered Medical Services

Here is a list of some of the medical services and benefits that Meridian covers.

Primary Care	
Routine Physical Exam	Covered
Physician Services	Covered
Diagnostic Tests	Covered — May require PA
X-Rays and Laboratory	Covered — May require PA
Immunizations and Vaccines	Covered — Certain immunizations may require PA
Allergy Testing and Treatment	Select services require PA
Audiology Services	Covered
Optometry Services	Covered — May require PA
Wellness Services	Covered
Well-Care Visits for Women	Covered
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services	Covered — Early and Periodic Screening, Diagnostic and Treatment (EPSDT) are services provided by Meridian for members ages 0-20 years of age. These services are meant to detect problems early; check your child's health often; provide medical, dental, vision, hearing and developmental screenings; run diagnostic tests when problems are found; control or correct problems that are found. Contact Member Services to schedule an appointment.
FQHC/RHC/Encounter Rate Clinic (ERC) Visits	Covered
Women's Care	
Abortion Services	Covered by Medicaid (not your MCO) by using your HFS medical card
Obstetric and Maternity Care	Covered
Birth Control	Covered — Certain contraceptives may require PA
Outpatient Care	

Outpatient Surgery	Covered — May require PA
Ambulatory Surgical Treatment Center (ASTC) Services	Covered — May require PA
Rehabilitative Therapy	Covered — May require PA
Cardiac and Pulmonary Rehab	Covered — May require PA
Testing and Diagnostic Treatments	Covered — May require PA
Inpatient	
Inpatient Surgeries	Covered — PA required
Inpatient Admissions	Covered — PA required
Organ Transplants	Covered — PA required
Nursing Facility Services	Covered — Care must be ordered by a provider and requires skilled professionals (e.g., nurses, therapists); PA required
Mental Health Services	
Inpatient Psychiatric Services	Covered — PA required
Intensive Outpatient (IOP) and Partial Hospitalization (PHP) Psychiatric Care	Covered — May require PA
Behavioral Health Office Visits	Covered — May require PA
Outpatient and Community-Based Services	Covered — PA required
Subacute Alcoholism and Substance Abuse Services	Covered for services in partnership with IL Department of Substance Use Prevention and Recovery (SUPR); Outpatient Services Residential Rehabilitation for Adults and Adolescents, Detoxification and Medication-Assisted Therapy — may require PA
Emergency and Urgent Care/Hospital Services	
Emergency Services	Covered
Hospital Ambulatory Services	Covered

Post-stabilization Care	Covered — Post-stabilization Care are services provided following a medical emergency; once you have been initially treated and are in a stable condition, services become post-stabilization services
Urgent Care Visits	Covered
Hospice	
Palliative and Hospice Care	Covered — PA required
Other Covered Services	
Nursing Care	Covered — PA required
Care Coordination	Covered
Advanced Practice Nurse	Covered
Pharmacy Services	Covered — May require PA
Durable Medical Equipment (DME)	Covered — May require PA
Services to Prevent Illness and Promote Health	Covered
Physical, Occupational and Speech Therapy Services	Covered
Hearing Aids	Covered — PA required
Diabetes Care	Covered — PA required
Nutritional Counseling (prescribed by a provider)	Covered — May require PA
Optical Services and Supplies	Covered — May require PA
Podiatry (foot) Care Prosthetic and Orthotics	Covered Covered — May require PA
Home Health Care	Covered — May require PA
Renal Dialysis Services	Covered — Notification requested
Respiratory Equipment and Supplies	Covered — May require PA
Blood, Blood Components, Including Administration	Covered — May require PA

Transportation (non-emergency) to secure covered services	*Subject to change based on non-emergent transportation regulations determined by the Illinois Department of Healthcare and Family Services*
Chiropractic Services	Covered — May require PA
Smoking Cessation (quitting smoking)	Covered
Assistive/Augmentative Communication Devices	Covered — Requires PA
Dental Services, including oral surgeons	See Dental Services section for details on your dental benefit
Sterilizations	Covered
Pain Management Injections	Covered — May require PA
Family Planning Services and Supplies	Covered
Medical Supplies, Equipment, Prostheses and Orthoses	Covered
Unlisted or Not Otherwise Specified	PA required
Children's Care	
Newborn Care	Covered
Lead Screening	Covered
Office Visits	Covered — Advanced Practice Registered Nurse services

Covered Home and Community Based Services (Waiver Clients Only)

Here is a list of some of the medical services and benefits that Meridian covers for members who are in a Home and Community Based service (HCBS) waiver.

Department on Aging (DoA), *Persons who are Elderly:*

- Adult Day Service
- Adult Day Service Transportation
- Homemaker
- Personal Emergency Response System (PERS)

Department of Rehabilitative Services (DRS), *Persons with Disabilities, HIV/AIDS:*

- Adult Day Service
- Adult Day Service Transportation
- Environmental Accessibility Adaptations-Home
- Home Health Aide
- Nursing Intermittent
- Skilled Nursing (RN and LPN)
- Occupational Therapy
- Home Health Aide
- Physical Therapy
- Speech Therapy
- Homemaker
- Home Delivered Meals
- Personal Assistant
- Personal Emergency Response System (PERS)
- Respite
- Specialized Medical Equipment and Supplies

Department of Rehabilitative Services (DRS), *Persons with Brain Injury:*

- Adult Day Service
- Adult Day Service Transportation
- Environmental Accessibility Adaptations-Home
- Supported Employment
- Home Health Aide
- Nursing, Intermittent
- Skilled Nursing (RN and LPN)
- Occupational Therapy
- Physical Therapy
- Speech Therapy
- Prevocational Services
- Habilitation-Day
- Homemaker
- Home Delivered Meals
- Personal Assistant
- Personal Emergency Response System (PERS)
- Respite
- Specialized Medical Equipment and Supplies
- Behavioral Services (M.A. and Ph.D.)

Healthcare and Family Services (HFS), *Supportive Living Facility:*

- Assisted Living

Managed Long Term Support & Services (MLTSS) Covered Services

MLTSS Covered Services include:

- Mental health services like: Group and Individual Therapy, Counseling, Community Treatment, Medication Monitoring and more
- Alcohol and substance use services like: Group and Individual therapy, Counseling, Rehabilitation, Methadone services, Medication Monitoring and more
- Some transportation services to appointments
- Long Term Care services in skilled and intermediate facilities
- All Home and Community Based Waiver Services like the ones listed above under "Covered HCBS Services" if you qualify

Limited Covered Services

- Meridian may provide sterilization services only as allowed by State and federal law
- If Meridian provides a hysterectomy, Meridian will complete HFS Form 1977 and file the completed form in the member's medical record

Non-Covered Services

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

- Services that are experimental or investigational in nature
- Services that are provided by a non-Network Provider and not authorized by Meridian
- Services that are provided without a required referral or required prior authorization
- Elective cosmetic surgery

- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies

For additional information on services, contact Member Services at **866-606-3700**, Monday through Friday, 7 a.m. to 5:30 p.m.

Dental Services

Dental services are a covered benefit for all members. We work with a dental vendor for your dental check-ups. Your dental benefits include:

- Routine preventive exams and cleanings up to two times a calendar year (Jan. 1-Dec. 31)
- One X-ray in a calendar year
- Limited and comprehensive exams
- Restorations
- Extractions

Eligible pregnant women can get additional dental services prior to the birth of their babies:

- Periodic oral exam
- Teeth cleaning
- Periodontal work

Please check the grid for more information on dental benefits.

Meridian Dental Coverage	Under 21	Age 21+
Diagnostic		
Oral Exam (up to two times in a calendar year)	Covered	Covered
X-rays (one in a calendar year)	Covered	Covered
Preventive		
Prophylaxis – Cleaning (once every 6 months)	Covered	Covered
Fluoride	Covered	NA
Restorative		

Amalgams	Covered	Covered
Resins	Covered	Covered
Crowns	Covered	Covered
Protective Restoration	Covered	Covered
Endodontic		
Root Canal (limitations for adults)	Covered	Covered
Pulpotomy	Covered	
Periodontal		
Scaling and Root Planting	Covered	Covered
Removable Prosthetics		
Complete Denture (upper and lower)	Covered	Covered
Partial Denture (upper and lower)	Covered	
Denture Repair	Covered	Covered
Denture Relines	Covered	Covered
Oral and Maxillofacial Services		
Extractions	Covered	Covered
Surgical Extractions	Covered	Covered
Alveoplasty	Covered	Covered
Orthodontia		
Orthodontia	Covered	NA

Vision Services

Eye care and eyeglasses

You may visit your optometrist for your eye care needs without prior authorization. They can test your vision and fit you for glasses. Members over 21 years old are limited to one pair of eyeglasses every two years. This limit does not apply if you need new glasses after a surgical procedure like cataract surgery. For children through age 20, eyeglasses are replaced as needed.

Contact lenses are covered with prior authorization for certain diagnosis when other medical treatments are not adequate. Children less than the age of three who have an aphakic diagnosis do not require prior authorization.

Pharmacy Services

Meridian lists covered pharmacies for you to use. To find a pharmacy, visit the Meridian website at ilmeridian.com. Select “Pharmacy Lookup” under the “For Members” menu to find a Meridian network pharmacy near you. You can also call 855-580-1688 if you need help.

What is a preferred drug list (PDL)?

A PDL, or Preferred Drug List, is a list of drugs that can be used for treatment and to improve health outcomes. The Meridian Medicaid Plan PDL is based on the Illinois PDL. Meridian uses clinical advice from providers, pharmacists, and other medical experts to create the most up-to-date PDL. The PDL includes prescription drugs and some over-the-counter drugs.

The PDL is on our website at ilmeridian.com. The formulary information can be found by clicking “Benefits and Services,” and then “Pharmacy.” Call 855-580-1688 if you want a printed copy.

The PDL includes drugs that are covered and drugs that need prior authorization. If a drug on the PDL needs prior authorization, your provider will need to submit a prior authorization request form. If a prior authorization is approved, the drug will be covered. Your provider can fill out the prior authorization request form and fax it to the Pharmacy Help Desk at 855-580-1695.
If a medication is covered or approved, your provider needs to write you a prescription to get it filled at a local pharmacy.

How can I request an exception?
There are drugs that are not on the PDL. We do not cover or pay for drugs that are not on the PDL unless there is an exception.
Some drugs are excluded by the State of Illinois. No exceptions can be made for those drugs.

If a drug does not work for you or the drug makes you sick, your provider can ask for a different drug. Your provider will need to fill out a prior authorization form if the new drug is not on the PDL. Your provider can fax the form to 855-580-1695.

Medication received in a provider's office also requires prior authorization.

Note: *We must approve the exception before you can fill the drug your provider prescribes.*

Call the Pharmacy Services team at 855-580-1688 (TTY: 711) if you have questions.

Meridian Medicaid Plan members do not have to pay copays for covered or approved drugs.

Transportation Services

Emergency Transportation

Meridian covers ambulance services in emergency situations without a prior authorization. Call 911 in case of an emergency.

Routine Transportation (Non-Emergent)

Meridian members have options for transportation to and from:

- Behavioral health visits
- Durable medical equipment (DME) vendors
- Family Case Management
- The provider
- Women, Infant and Children (WIC) offices

Gas Reimbursement

Meridian also offers gas reimbursement if you are able to drive yourself or if you get a ride to and from any qualifying appointments. You must call **866-796-1165** before your appointment to get this benefit.

Call **866-796-1165** at least three days before your appointment to talk about your transportation options, schedule a ride or start the process for gas reimbursement. Have the following ready when you call:

- 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
- Additional riders and their ages
- The name of your provider
- Special equipment or needs (e.g., wheelchair; combined weight of the person and wheelchair; can walk to and from car)

To request ride assistance for urgent trips or a ride home after being discharged from the hospital, you may contact Meridian Transportation 24 hours a day, 7 days a week.

Please call **866-796-1165** if you need to cancel your ride. You should cancel as soon as you know you don't need a ride. You may also call to learn more about your transportation options. Call Member Services or your Care Coordinator if you have questions about transportation.

Behavioral Health

Behavioral health services are a type of healthcare that offers emotional support, treatment, counseling and guidance. Meridian covers inpatient hospital psychiatric services, outpatient partial hospitalization services (PHP) and intensive outpatient services (IOP). Meridian also covers community and outpatient services in partnership with DHS Mental Health Rehab Option Services.

Substance use services are covered benefits through Meridian's partnership with the Divisions of Substance Use Prevention Recovery (SUPR). Inpatient substance use disorder (SUD) detoxification services are covered once every 60 days. Additional covered substance use services include:

- Detoxification
- Outpatient services
- Intensive outpatient
- Screening and assessment

Meridian is committed to ensuring access to children's mental health services. We provide wraparound services for your family to help with your child's mental health needs through opportunities like our Family Driven Care Plan and our Family Leadership Council.

Meridian also offers a Behavioral Health Crisis Line. It is available 24 hours a day, 7 days a week by calling **800-345-9049**. All services are confidential.

Added Benefits

Healthy Incentives

Meridian offers incentives like gift cards to eligible members for getting certain services. You may get a postcard or flyer by mail offering an incentive for getting preventive services like:

- Breast cancer testing
- Cervical cancer testing
- Diabetes care
- Pregnancy care

Member newsletters are emailed monthly and mailed out four times a year. We will inform you about important health topics, benefit updates, policy changes and community events. For more information, or to update your contact information, Member Services is available at **866-606-3700**.

Cost Sharing

Meridian 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, pre-authorized services or medical supplies. If you get a bill by mistake, send it to the address below:

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

Please call Member Services at **866-606-3700** if you have any problems with medical bills for covered care.

You may get a bill for care you had before you joined Meridian. Call your provider's office for help for this type of bill.

Care Coordination

If you qualify for care coordination and choose to stay in care coordination, a Care Coordinator will be assigned to you. Your Care Coordinator will work with your health plan to assist you in managing your care.

What is Care Coordination?

Care Coordination is a program that helps enrolled members get the right services in the right setting at the right time. Care Coordination uses a holistic approach to care to link you to services and resources in your community that help improve your health and overall well-being while arranging care with your care team and providers. Our goal is to offer personal care for you and to help make your quality of life better.
Do you have a chronic health problem or disability? Do you have barriers that are causing you issues accessing your care? Do you see multiple providers or need special care? Meridian is here to help you! We have Care Coordinators that include nurses, social workers and other healthcare experts to help you and your care team.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own Care Coordinator. This person helps you get the care you need by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Helping you to know your benefits
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

Call Member Services at **866-606-3700** for more information or to request a Care Coordinator.

What to Expect from Your Care Coordinator

A member of the Care Coordination team will reach out within 60 days of enrollment in Care Coordination. The Care Coordinator will attempt to reach you by phone, mail or in person to complete a Welcome Call, Health Risk Screening/Assessment, and Individual Plan of Care (IPoC).

During the Welcome Call, you will be informed of the plan benefits and receive an introduction to the Care Coordination program.

Community Health Workers (CHW)

The Community Health Workers (CHWs) are the frontline public health workers in the community, helping members navigate their healthcare. CHWs serve as a bridge between healthcare and social services by building trusting relationships. CHW services include:

- Conducting home visits to assess health barriers, including follow-up after hospitalization and emergency room
- Advocating for members with providers
- Arranging for social support services (i.e., food and housing assistance)
- Help boost member morale, sense of self-worth and encourage self-management skills
- Helping with quality outreach initiatives
- Helping to remove barriers to healthcare services, including connection to community resources and reminders about scheduled visits

Disease/Health Education Management Programs

Smoking Cessation Program

You may be eligible for the Meridian Smoking Cessation Program, “New Beginnings.” This program offers:

- Educational materials
- Access to trained staff who can coach and support you
- Coaching calls to help you through quitting

Call **844-854-5576** and ask about our free program if you would like to quit smoking.

Disease Management Program

Disease Management (DM) helps you manage your health. DM is for members with asthma, attention deficit hyperactivity disorder, cardiovascular disease, chronic obstructive pulmonary disease, depression, anxiety, substance abuse, diabetes, and hypertension. DM gives members support from nurses and healthcare staff, and provided educational materials and newsletters to help you learn how to manage your condition. We will remind you about the preventive care you need to stay healthy. If you have asthma, attention deficit hyperactivity disorder, cardiovascular disease, chronic obstructive pulmonary disease, depression, anxiety, substance abuse, diabetes, or hypertension, you may be signed up automatically by Meridian. You can also sign up for the program by calling **866-606-3700** or your provider can sign you up.

As part of the Disease Management program, you will get:

- A welcome packet
- Information about your health issue
- Reminders of needed healthcare

Population Health Management Programs

The Population Health Management programs section provides various programs offered to Meridian members to improve their overall health and quality of care.

Program Name	Description
Complex Case Management	Meridian's Complex Case Management Program helps members with all their healthcare needs by giving them tools to manage their chronic conditions, appointments and benefits.
Fluvention®	The Fluvention® Program is an educational program used to increase access to the flu vaccine, add value to preventive care and keep members healthy.
Smoking Cessation	The Meridian Smoking Cessation Program offers educational materials, access to trained staff who can coach and support members and coaching calls to help members quit smoking.

Please speak to your provider or call Member Services at **866-606-3700** for more information.

How do I become part of a Special Healthcare Program?

- Your primary care provider (PCP) can refer you to the program
- You can refer yourself to the program by calling **866-606-3700**
- You can also sign up using our member portal at **member.ilmeridian.com**
- You may be signed up automatically when Meridian pays a bill related to your health issue (e.g., lab test, medicine or office visit)

Please call **866-606-3700** if you want to be taken out of a healthcare program. We'll be happy to help you.

Flu Prevention

The flu vaccine is a safe and recommended way for children, adults and pregnant women to avoid illness from influenza (flu). You must get the flu

shot every year in order to stay protected! The vaccine is highly recommended for those with chronic conditions as contracting the flu can result in serious health complications.

Fight symptoms of the flu by getting an annual flu shot. You can get this at a local pharmacy or through your provider. Tips to prevent infection are:

- Always wash your hands with soap and water
- Cover your coughs and sneezes with tissue
- Contact your provider if symptoms become severe

You should stay home for at least 24 hours if sick with flu-like symptoms unless you require medical care or other necessities. Avoiding close contact with sick people is important to prevent flu complications. For more information about flu prevention, talk with your provider about best practices and for more information on the flu vaccine.

Community Healthcare Resources

Family Case Management

The Family Case Management (FCM) Program supports healthy pregnancies and healthy children. It is open to Medicaid-eligible pregnant women. It also serves infants and high-risk children with Medicaid. Meridian works with the FCM Program to help coordinate your care. This can include:

- Coordinating services with FCM
- Sharing information with your FCM providers
- Finding ways for Meridian, our provider network and FCM providers to work together
- Having meetings with FCM providers to help solve any issues

Meridian identifies pregnant women and high-risk children eligible for FCM and refers them to the FCM program closest to their homes. Your provider may also refer you for FCM services. FCM services include:

- Visits during and after pregnancy; these will help you take care of yourself and your baby

- Access to healthcare professionals that will teach you about pregnancy, labor and delivery, caring for your new baby and family planning
- Referrals to childbirth, parenting and other classes

The FCM program also works with community agencies to help you with:

- Medical services
- Childcare
- Transportation
- Housing
- Food
- Mental health needs
- Substance abuse services

Please call Member Services at **866-606-3700** if you have questions about the FCM Program.

Cultural Competency

Cultural Competency is a set of attitudes, behaviors and policies that help people with different ideas and beliefs work together. Meridian is dedicated to educating our employees and partners on cultural competency to help provide the best healthcare for our members. Meridian hosts focus groups that discuss your care, feedback and our cultural competency. Focus groups are open to members. If you are interested in attending one of these workgroup meetings, please call Member Services at **866-606-3700**.

Women, Infants and Children (WIC)

WIC helps moms and their children get food coupons, health education and nutrition support. You must meet certain conditions to get WIC resources. You can call WIC at **217-782-2166** for more information. Please call Meridian if you have questions.

Recipient Restriction Program

Meridian's Recipient Restriction Program will help you if you are over-utilizing your services. If you are part of the Recipient Restriction

Program, you may be restricted to get services from a designated pharmacy or your PCP. The restriction is not permanent. You will be notified by mail if you are included in this program. You have the right to file an appeal if you are placed in this program and do not wish to stay in.

Advance Directives

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

- **Healthcare Power of Attorney** – This lets you pick someone to make your healthcare decisions if you are too sick to decide for yourself
- **Living Will** – This tells your PCP and other providers what type of care you want if you are terminally ill which means you will not get better
- **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
- **Do Not Resuscitate (DNR) Order** – This tells your family and all your doctors and other 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 an advance directive. You do not need 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.

If you have questions about advance directives, call Member Services at **866-606-3700**. Information on advance directives is available on the Meridian website at **ilmeridian.com**. You can get advance directive forms at your provider's office or local hospital.

Grievances & 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.

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 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 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 **866-606-3700**. You can also file your grievance in writing via mail or fax:

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 **866-606-3700**.

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. 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 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 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 about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Adverse Benefit Determination letter.
The list below includes examples of when you might want to file an appeal:

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to choose your 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 **866-606-3700**. If you file an appeal over the phone, you must follow it with a signed written appeal request
2. Mail or fax your written appeal request to:

   Meridian
   Attn: Grievance and Appeals Dept.
   PO Box 44287
   Detroit, MI 48244
   Fax: **833-383-1503**

   For pharmacy services:
   Meridian Pharmacy Appeals
   P.O. Box 31383
   Tampa, FL 33631-3383
   Phone: 855-580-1688 or TDD/TTY 711
   Fax: 833-433-1078

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. Call the Illinois Relay at **711** if you are hearing impaired.

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 PCP 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**.

Appeal Process

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

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

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

How Can You Withdraw an Appeal?

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

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 **866-606-3700**.

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 **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 continuance or postponement.

Failure to Appear at the Hearing

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

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

Within **thirty (30) calendar days** after the date on the 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 a decision within **five (5) calendar days** of receiving all the information need to complete the 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 **866-606-3700**. 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.

MeridianHealth
Attn: Grievance and Appeals Dept.
PO Box 44287
Detroit, MI 48244
Fax: 833-383-1503

For pharmacy services:
Meridian
Grievance and Appeals Coordinator
1 Campus Martius, Suite 750
Detroit, MI 48226
Phone: 855-580-1688
Fax: 833-433-1078

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 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 **forty-eight (48) hours**.

Rights & Responsibilities

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 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 Meridian, 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 Meridian 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

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 they are not entitled to. Some examples of fraud are:

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

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

- Sexual abuse is when someone is touching you inappropriately and without your permission
- 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

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

If you believe you are a victim, you should report this right away. You can call Member Services at **866-606-3700***.*

Nursing Home Hotline: 844-528-8444

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 (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 2 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 healthcare 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. An example of this is 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 people 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 services outside of the plan's contracted network of providers. In some cases, a member'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 preauthorization, 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 Doctor or D.O. — Doctor 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 provider 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.

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: **866-606-3700** (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 **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 **www.hhs.gov/ocr/complaints/index.html**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-606-3700 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 866-606-3700 (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 866-606-3700（TTY：711）。

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866-606-3700 (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 866-606-3700 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 866-606-3700 (رقم هاتف الصم والبكم: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866-606-3700 (телетайп: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ

તમારા માટે ઉપલબ્ધ છે. ફોન કરો 866-606-3700 (TTY: 711).

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں کال کریں -866-606-3700 (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 866-606-3700 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 866-606-3700 (TTY: 711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 866-606-3700 (TTY: 711) पर कॉल करें।

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 866-606-3700 (ATS : 711).

λ λ η ν ι κά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 866-606-3700 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 866-606-3700 (TTY: 711).

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 this section carefully. If you would like the full Notice of Privacy Practices, visit **ilmeridian.com** or call Member Services at **866-606-3700** 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 healthcare. 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 written authorization to do so. If you give us 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.

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 INFORMATIONATION. 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

You can also visit their website at **www.hhs.gov/ocr**.

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 **866-606-3700**. You will not be penalized for filing a complaint. You can view a copy of this notice on our website at **ilmeridian.com**.

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State Approved: 2021/03/31

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