here's *your* member handbook.

Meridian Medicaid Plan for Illinois residents

Effective July 1, 2022

important phone numbers & contacts

Need help? Here are the numbers to call.

Meridian:

Member Services
866-606-3700 (TTY: 711)

Transportation Services (non-emergency)
866-796-1165

Behavioral Health Services
866-796-1167

Pharmacy Services Team
855-580-1688 (TTY: 711)

24/7 Nurse Advice Line
866-606-3700

You can also contact us online at member.ILmeridian.com

Illinois Department of Healthcare and Family Services (HFS):

Illinois Client Enrollment Services (CES)
877-912-8880 (TTY: 866-565-8576)

Women, Infants, and Children (WIC)
217-782-2166

To find your local HFS office, go to www.dhs.state.il.us and click on "DHS Office Locator" under the "About DHS" section.

In an emergency:

Call 911

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Meridian Member Services
866-606-3700
Monday–Friday, 7:00 a.m. to 5:30 p.m. (TTY: 711)

Service area
Meridian covers all counties in Illinois. Moving? Don't forget to call your local HFS office and Meridian Member Services with your new address.

learn all about *your* new health plan.

Welcome to Meridian! We're so happy you're here.

This handbook will help you get the most out of your Meridian plan. It includes information about your coverage and benefits. It also explains how to find a provider, how to get no-cost prescriptions, and more.

Questions? We're here to help. Just give us a call at 866-606-3700. We're here Monday to Friday, 7:00 a.m. to 5:30 p.m.

Member Services

we're here to support *you*.

Meridian Member Services is here to help you get the most from your health plan. Call us at **866-606-3700**, Monday–Friday, 7:00 a.m. to 5:30 p.m. (TTY: 711). We can answer questions about your plan or help you:

- Get more information about your benefits
- Find a primary care provider (PCP)
- Change your PCP
- Get a new Member Identification Card or handbook
- Change your address or phone number
- File a complaint

Be sure to have your Illinois Medicaid ID number ready when you call. This number can be found on your Member Identification Card (see below).

Have a health question? Our 24/7 Nurse Advice Line is here for you. You can talk to a trained nurse anytime by calling **866-606-3700**. We are also available 24/7 to confirm eligibility for benefits.

Member ID Cards

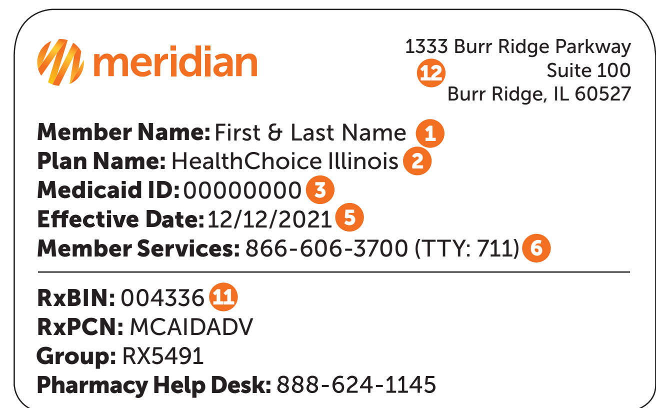
about *your* member ID card

You should have received your member identification (ID) card in the mail. Always carry your Member ID card with you. It has important information and phone numbers on it. You will need to show your Member ID card when you get services.

Didn't get a member ID card, or need a replacement? Call Member Services.

Find what you need on your Member ID card

1. Your name
2. Plan name
3. State Medicaid ID number
4. Primary care provider (PCP) information
5. Effective date
6. Member Services phone number
7. 24/7 Nurse Advice Line phone number
8. Behavioral Health Services phone number
9. Dental Services phone number
10. Transportation Services phone number
11. Prescription coverage information for providers
12. Meridian address
13. How to submit claims (for providers only)



meridian

1333 Burr Ridge Parkway (12)
Suite 100
Burr Ridge, IL 60527

Member Name: First & Last Name (1)
Plan Name: HealthChoice Illinois (2)
Medicaid ID: 00000000 (3)
Effective Date: 12/12/2021 (5)
Member Services: 866-606-3700 (TTY: 711) (6)

RxBIN: 004336 (11)
RxPCN: MCAIDADV
Group: RX5491
Pharmacy Help Desk: 888-624-1145

PCP: <Name> (4)
Phone: <Phone>

Send claims to: (13)
Meridian
PO Box 4020
Farmington, MO 63640-4402

24/7 Nurse Advice Line: 866-606-3700 (7)
Behavioral Health: 866-606-3700 (8)
Dental: 866-245-2770 (9)
Transportation: 866-796-1165 (10)

Open Enrollment

what does "open enrollment" *mean*?

Once per 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 period to make a plan switch by calling CES at **877-912-8880**. After the 60 days have 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 call CES at **877-912-8880** (TTY: 866-565-8576).

Provider Network

what is a *provider* network?

A provider network is the group of providers that Meridian has contracted with to provide your care. Our provider network includes:

- Primary care providers (PCPs)
- Specialists
- Hospitals
- Urgent care centers
- Vision care providers
- Behavioral health care providers
- Dentists
- Pharmacies
- Other healthcare providers

The Meridian Medicaid Plan's Provider Directory lists the providers in our network. The Provider Directory also has information about each provider. This information includes the provider's address, office hours, board certifications and status, professional qualifications, and languages spoken. It can also include where each provider completed his/her medical school and residency programs.

You can search the Provider Directory at 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 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 need, 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)

what is a *PCP*?

Your primary care provider (PCP) is your personal provider who will give you most of your care. Your PCP may also send you to other providers if you need special care. With the Meridian Medicaid Plan, 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)
- FQHC or RHC
- Other specialists based on medical necessity

For American Indian/Alaskan Native tribe members: You have the right to get PCP services from an Indian Tribe, Tribal Organization, or Urban Indian Organization provider in and outside of the State of Illinois.

PCP services may include:

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

How to Change Your PCP

need a *new* PCP?

You can change your PCP at any time. Please contact Member Services at **866-606-3700**, Monday to Friday, 7:00 a.m. to 5:30 p.m. You can also change PCPs online. Just log on to your Member Portal at **member.ILmeridian.com**.

Women's Healthcare Provider (WHCP)

for women: choose a PCP who specializes in *you*.

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

How to enroll your newborn

When you have a baby, call your caseworker as soon as possible. Your caseworker will add your baby to your case. This is the first step to sign your baby up for Meridian.

Then, call Member Services and tell us the day you gave birth, the baby's name, and the baby's Medicaid ID number you get from the caseworker.

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 (page 23) for more information.

Family Planning

get the family planning care *you* need.

The Meridian Medicaid Plan 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.

Scheduling Appointments

how to *schedule* your care appointments

It is very important that you keep all appointments you make for doctor 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 in making an appointment, please contact Members Services at **866-606-3700**.

Specialty Care

how to get *specialist* care

A specialist is a provider who cares for you for a certain health condition. An example of a specialist is a 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 provider. Your PCP will then arrange your specialty care.

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

You can use Meridian's online Provider Directory to find a list of specialists in your area at **findaprovider.ILmeridian.com**. You can call Member Services at **866-606-3700** for more information. If you have a Care Coordinator, he or she can also help you find a specialist.

Member Committees

let us know how we can *improve*.

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**.

24/7 Nurse Advice Line

get health advice on *your* schedule.

The 24/7 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 24/7 Nurse Advice Line by calling **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. We recommend saving the toll-free number into your cell phone for easy access.

Call the 24/7 Nurse Advice Line if you have:

- Fever, cough, or sore throat
- Earache or headache
- Cold or flu
- Asthma, diabetes, or other chronic conditions
- Back or joint pain
- Cuts, scrapes, or minor burns
- Injuries from slips and falls
- Other health concerns

You can also call the 24/7 Nurse Advice Line if you think your crying baby may have an upset stomach or if s/he is vomiting.

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

Urgent Care

how to get *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
- Earache

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

how to get *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, or
- Call an ambulance if there is no 911 service in your area

No referral is needed for emergency care. Prior authorization is also 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

how to get care *after* an emergency

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

about the care services we *cover*

It is important you understand the care services covered under your plan. As a Meridian Medicaid Plan member, you do not have to pay copays for covered services.

On the following pages, you'll see what's covered under your plan. 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.

About Prior Authorizations

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. If you need a care service that requires PA, your provider needs to fill out a PA Request Form and send it to us.

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 are the *medical* services that are covered by your plan.

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 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 Program (IOP) and Partial Hospitalization Program (PHP) for 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 Misuse 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 Prosthetics and Orthotics	*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*

Other Covered Services, continued

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)

have a *waiver?* here's what's covered.

Here is a list of some of the medical services and benefits that the Meridian Medicaid Plan covers for members who are in a Home and Community Based Services 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 or who have 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
- 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)
- Speech therapy
- Occupational therapy
- Physical 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)
Persons in a supportive living facility

- Assisted living

Managed Long Term Services and Support (MLTSS) Covered Services

check out our MLTSS *covered* services.

If you're part of the MLTSS program, some more services are covered. These services include:

- Mental health services like group and individual therapy, counseling, community treatment, medication monitoring, and more
- Alcohol and substance misuse 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 HCBS waiver services like the ones listed under "Covered Home and Community-Based Services (Waiver Clients Only)" if you qualify

Limited Covered Services

review services with *limited* coverage.

There are a few services that may not be covered in full by your plan. These services include:

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

Non-Covered Services

know what services are *not* covered.

Here is a list of some of the medical services and benefits that your plan 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 more information, contact Member Services. Call **866-606-3700** (TTY: 711), Monday to Friday, 7:00 a.m. to 5:30 p.m.

Dental Services

we cover *dental* care for members of all ages.

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 (January 1 to December 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

Find out what's covered. Explore the chart below.

Diagnostic	Under 21	Age 21+
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*	N/A

Restorative

Amalgams	*Covered*	*Covered*
Resins	*Covered*	*Covered*
Crowns	*Covered*	*Covered*
Protective Restoration	*Covered*	*Covered*

Endodontic

Root Canal (limitations for adults)	*Covered*	*Covered*
Pulpotomy	*Covered*	N/A

Periodontal

Scaling and Root Planing	*Covered*	*Covered*

Removable Prosthetics

Complete Denture (upper and lower)	*Covered*	*Covered*
Partial Denture (upper and lower)	*Covered*	N/A
Denture Repair	*Covered*	*Covered*
Denture Relines	*Covered*	*Covered*

Oral and Maxillofacial Services

Extractions	*Covered*	*Covered*
Surgical Extractions	*Covered*	*Covered*
Alveoloplasty	*Covered*	*Covered*

Orthodontia

Orthodontia	*Covered*	N/A

Vision Services

see your covered *vision* services.

Eye care visits: You may visit your optometrist for your eye care needs without prior authorization. They can test your vision and fit you for glasses.

Glasses: Members over 21 years of age 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: Contact lenses are covered with prior authorization for certain diagnoses when other medical treatments are not adequate. Children under the age of three who have an aphakia diagnosis do not require prior authorization.

Pharmacy Services

learn how to get *no-cost* prescriptions.

To get no-cost prescriptions, you need to use an in-network pharmacy. To find an in-network pharmacy, use our online Provider Finder. Go to **findaprovider.ILmeridian.com**. Enter your address or zip code, and then select "Pharmacy & Medical Supplies." You can also call our Pharmacy Services Team at **855-580-1688**.

What is a preferred drug list (PDL)?

A preferred drug list (PDL) 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 has prescription drugs and some over-the-counter drugs.

The PDL is on our website at **ILmeridian.com**. Click "For Members," then "Benefits and Services," 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.

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

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 these 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 Meridian at **855-580-1695**.

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

We must approve the exception before you can fill the prescription.

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

Transportation Services

getting where you need to *go*

Meridian offers transportation services to help members access care services.

If it's an emergency: Call 911 or an ambulance. Your plan covers ambulance services in emergency situations. No prior authorization (PA) is needed.

If it's not an emergency: Your plan covers transportation to and from the places you need to go to take care of your family. These places include:

- Provider offices
- Behavioral health appointments
- Family Case Management sites
- Durable medical equipment (DME) vendors
- Women, Infant, and Children (WIC) offices

You can request a free ride from Meridian for these trips. We will pick you up or give you a bus ticket. Meridian also offers gas reimbursement if you are able to drive yourself or if you get a ride to and from any qualifying appointments.

Call us at **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. Be sure to 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 (for example, if you have a wheelchair or if you need help walking to and from the car)

To request ride assistance for urgent trips or a ride home after being discharged from the hospital, you can call us 24 hours a day, 7 days a week, at **866-796-1165**.

Need a stretcher or ambulance to safely get where you're going? Contact First Transit, our contractor for non-emergency ambulance services. Just call **877-725-0569**. First Transit is available Monday to Friday, 8:00 a.m. to 5:00 p.m.

If you need to cancel your ride: Please call **866-796-1165** as soon as you know that you don't need a ride.

Questions? Call Member Services or your Care Coordinator.

Behavioral Health Services

check out *covered* services for mental health and substance misuse.

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

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

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

For children: 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.

Behavioral Health Crisis Line: Your plan 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 & Rewards

get *rewarded* with Meridian!

Through our Healthy Rewards program, you can earn rewards for taking care of your health. When you do things like visit your provider and complete health screenings, you can earn reward dollars. You can redeem these rewards for gift cards.

You may get a postcard or flyer by mail letting you know about rewards for getting preventive services like:

- Annual physical/ check-up
- Breast cancer testing
- Cervical cancer testing
- Diabetes care

To start earning, log on to your Member Portal at **member.ILmeridian.com**. You can also call Member Services.

Help your baby start life off *bright*.

Through our Start Smart for Your Baby® program, we offer advice and resources to pregnant members and new parents. We also host baby showers throughout the year with lots of educational materials and giveaways.

To enroll, just complete a Notification of Pregnancy form. This can be done in your Member Portal. You can also call Member Services.

Moms: Here's how you can earn more with Healthy Rewards.

We want to support new parents throughout their journey. That's why new and expecting moms can earn:

- Up to $50 in gift cards for completing your Notification of Pregnancy form. (It's easy to do! Just log in to your Member Portal or call Member Services.)
- Up to $50 in gift cards for attending prenatal and postpartum visits. You can also get free baby gear (up to $140 value)

Cost Sharing

about your *no-cost* care

Meridian does not charge copays or have deductibles for its Medicaid members. This means that you should never get any bills for your covered benefits, preauthorized services, or medical supplies.

If you get a bill by mistake, send it to:

Meridian
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

get the support you need to live *healthier.*

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.

Meridian has Care Coordinators, including nurses, social workers, and other healthcare experts, to work with you and your care team. Our goal is to offer personal care for you and to help make your quality of life better.

You may qualify for Care Coordination if you:

- Have a chronic health problem or disability
- Are having trouble accessing the care you need
- See multiple providers
- Need special care

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 in understanding your medical and behavioral health benefits

Your Care Coordinator 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.

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

About Community Health Workers (CHWs)

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 care
- Advocating for members with providers
- Arranging for social support services (e.g., food and housing assistance)
- Helping boost member morale, sense of self-worth and encouraging 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

Health Management Programs benefit from special *support*.

We want all of our members to feel their best. That's why we offer special healthcare programs to help members with specific concerns. It's our way of making life brighter, one program at a time.

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.

Chronic Disease Management Program

We know it can be difficult to manage chronic medical conditions. The Chronic Disease Management (CDM) program is here to help. This program is for members with asthma, COPD, diabetes, heart failure, or heart disease. It is also for members who want to stop smoking.

All members who join this program get:

- Support from nurses and healthcare staff
- Educational materials and newsletters specific to your condition
- Reminders about the care you need to stay healthy

You may be automatically signed up for the CDM program If you have asthma, attention deficit hyperactivity disorder, cardiovascular disease, chronic obstructive pulmonary disease, depression, anxiety, substance misuse, diabetes, or hypertension. You can also sign up by calling Member Services at **866-606-3700**.

Population Health Management Programs

The Population Health Management programs help members improve their overall health and quality of care.

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.

How do I become part of a Health Management Program?

There are several ways to join a Health Management 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 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 Health Management program.

Remember, we're here to help you live healthier. If you have questions or need more support from us, just give us a call.

Flu Prevention

protect yourself and your family from the *flu*.

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

get support in your *community*.

We want to make sure our members get all the help they need to thrive. Get to know some of the resources that are right in your community.

Family Case Management Program

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 to help you take care of yourself and your baby
- Access to healthcare professionals who will teach you about pregnancy, labor and delivery, caring for your new baby, and family planning
- Referrals to classes about childbirth, parenting, and more

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

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

Call Member Services if you have questions about the FCM program.

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. Call Member Services with questions.

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**.

Recipient Restriction Program

learn when there may be *limits* on where you can get care services.

Our 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 getting 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

make your wishes *clear*.

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. Terminally ill 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. 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

how grievances and appeals *work*

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:

Meridian
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 of 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 following list 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: 833-669-1734

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**.

The 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 of 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 misuse 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

The 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:

Meridian
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 needed 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.

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

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

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

plan members have rights and responsibilities. here's what you need to *know*.

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); 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 policies

Your responsibilities:

- Treat your provider and the office staff with courtesy and respect
- Carry your member 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 contact information changes
- Read your Member Handbook so you know what services are covered and if there are any special rules

Fraud, Abuse, and Neglect

let us know when something isn't *right*.

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:

- 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. 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 withhold 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

here are *definitions* of common plan terms.

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

Copayment 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 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. 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.

Prescription Drug Coverage means health insurance or a 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.

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 that your health insurance or plan will cover the cost.

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.

disclaimers

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

Meridian:

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 Meridian 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:
Meridian
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, S.W.
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).

λληνικά (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 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

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:

Meridian Privacy Officer
1333 Burr Ridge Parkway
Suite 100
Burr Ridge, IL 60527

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**.

***contact* us.**

Meridian
Member Services

866-606-3700

Monday—Friday,
7:00 a.m. to 5:30 p.m.
(TTY: 711)

keep track of your family's *care* team.

Use this page to write down the names and contact information for the providers that your family sees regularly. This could include PCPs, dentists, OB-GYNs, specialists, therapists, and more. Need more space? Use the Notes section on the next page.

Provider name: ______________________

Specialty: ______________________

Phone number: ______________________

Address: ______________________

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Provider name: ______________________

Specialty: ______________________

Phone number: ______________________

Address: ______________________

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Provider name: ______________________

Specialty: ______________________

Phone number: ______________________

Address: ______________________

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Provider name: ______________________

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Provider name: ______________________

Specialty: ______________________

Phone number: ______________________

Address: ______________________

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Provider name: ______________________

Specialty: ______________________

Phone number: ______________________

Address: ______________________

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notes

Meridian Member Services:
866-606-3700 (TTY/TDD: 711)

member.ILmeridian.com

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State Approved: 7/26/2022

IL Member Handbook