meridian

HealthChoice Illinois

here's your member handbook.

Meridian Managed Long Term Services & Supports Plan for Illinois residents

Effective October 29, 2024

important phone numbers & contacts

Need help? Here are the numbers to call.

Meridian:

Member Services
866-821-2308 (TTY: 711)

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

Behavioral Health Services
866-821-2308 (TTY: 711)

24/7 Nurse Advice Line
866-821-2308 (TTY: 711)

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
866-821-2308 (TTY: 711)
Monday–Friday, 8:00 a.m. to 5:00 p.m.

Service area
You are eligible for Meridian services under the MLTSS program. Meridian operates in 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 the Meridian Managed Long Term Services & Supports (MLTSS) Plan. This plan coordinates your Medicaid-only services. We help connect you to nursing home care, waiver benefits, behavioral health services, free transportation, and more.

The goal of this plan is to help you thrive. We're here to help you take control of your health and live the life you want.

Questions? You can reach Member Services at **866-821-2308** (TTY: **711**), Monday through Friday, 8:00 a.m. to 5:00 p.m.

Member Services
we're here to help you take *care*.

Meridian Member Services is here to give you the support that you need. Call us toll-free at **866-821-2308** (TTY: **711**), Monday through Friday, 8:00 a.m. to 5:00 p.m. We can answer questions about your plan and eligibility. Have your Illinois Medicaid ID number ready when you call.

You can also call us 24/7 for medical guidance and support. We'll connect you to our team of nurses who can answer your questions and offer advice. This phone line is not for emergencies. If it's an emergency, call 911.

Interpreter Services and Alternative Formats

Meridian can arrange for an interpreter to help you speak with us or your healthcare provider in any language. Interpreter services are provided to Meridian members free of charge. We also offer materials in alternative formats. Alternative formats help members with different reading skills, backgrounds, or disabilities understand our materials. Please call Member Services if you need the Member Handbook or other materials in alternative formats.

For members with hearing and/or vision impairment, we offer:

- Free TTY services by dialing **711** (available 24/7)
- Braille versions of the Member Handbook and other materials
- Buttons on our website to make the print bigger and simpler to read. (If you need help accessing our website, call Member Services)

Cultural Competency

Cultural competency is a set of attitudes, behaviors, and policies that help people work with others whose ideas and beliefs are different from their own. Meridian is dedicated to the goal of educating our employees and partners on cultural competency to help provide the best healthcare for our members.

Meridian hosts focus groups that discuss your care, feedback, and our cultural competency. If you are interested in attending one of these workgroup meetings, please call Member Services.

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

Member ID Cards
about *your* member ID card

You should have received your Meridian member identification (ID) card in the mail. Always carry your member ID card with you. It has important information and phone numbers on it.

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

You should also have an Illinois Medicaid card. You will need to show both cards when you get services. You may also need to show a picture ID. This is to make sure that the right person is using the cards. Don't let anyone else use your cards.

Find what you need on your Member ID card

1. Your name
2. Plan name
3. State Medicaid ID number
4. Effective date
5. Member Services phone number
6. How to submit claims (for providers only)
7. 24/7 Nurse Advice Line phone number
8. Behavioral Health Services phone number
9. Transportation Services phone number

meridian

1333 Burr Ridge Parkway
Suite 100
Burr Ridge, IL 60527

Member Name: First & Last Name 1
Plan Name: HealthChoice Illinois – MLTSS 2
Medicaid ID: 000000000 3
Effective Date: 01/01/2024 4

Member Services: 866-821-2308 (TTY: 711) 5

PCP: Name 6
Phone: Phone

Send claims to: 7
Meridian
PO Box 4020
Farmington, MO 63640-4402

24/7 Nurse Advice Line: 866-821-2308 (TTY: 711) 8
Behavioral Health: 866-821-2308 (TTY: 711) 9
Transportation: 866-796-1165 10

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 **866-821-2308**.

Open Enrollment
what does "open enrollment" *mean*?

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

Then, 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**).

Disenrollment

You can change your health plan one time during the first 90 days. After that, you can only change your plan during Open Enrollment.

However, you can opt out of MLTSS at any time if you choose to enroll in a Medicare-Medicaid Alignment Initiative (MMAI) plan. Meridian's MMAI plan is called the Meridian Medicare-Medicaid Plan (MMP). This plan combines your Medicare, Medicaid, and prescription drug benefits into one health plan. To switch plans, call Illinois Client Enrollment Services at **877-912-8880**. You can also switch plans online at **enrollhfs.illinois.gov**.

Primary Care Provider (PCP)
your partner in living *healthier*

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.

Primary care is covered through your Medicaid or Medicare benefits. The Meridian MLTSS plan does not cover primary care. For questions about your PCP or other primary care services, contact your Medicaid or Medicare plan.

Covered Services
here's what's *covered* by your plan.

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

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

Prior Authorization

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

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

- Durable medical equipment (DME) products
- Services provided by out-of-network providers

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

Covered Services

Waiver Services

See details in Waiver Benefits section.

- Agency Providers: RN, LPN, CNA, and Therapies
- Individual Providers: PA, RN, LPN, CNA, and Therapies

Long-term Care

- Skilled
- Intermediate
- Nursing Facility Benefit

Behavioral Health

Behavioral health services are a type of healthcare that offers emotional support, treatment, counseling, and guidance. Meridian covers behavioral health services without a referral in partnership with DHS Mental Health Rehab Option Services. Our behavioral health staff can help you get the services you need. Please call us at **866-821-2308** (TTY: **711**). We can help you find a provider and make an appointment. All services are confidential.

- Mental Health Rehab Option Services
- Outpatient Behavioral Healthcare
- Alcohol and Substance Abuse Rehabilitation Services

Transportation

Many transportation options are available to and from office visits, behavioral health appointments, pharmacies, DME vendors, Family Case Management, and WIC offices. Please call **866-796-1165** to talk about your transportation options.

- Non-emergency ambulance transportation
- Medical transportation
- Additional transportation services (including taxicabs, service cars, private cars, and others)

Other Benefits

- Over-the-counter benefit: $10 per month. See section on Over-the-Counter (OTC) Drugs
- 24/7 Nurse Advice Line (See section on this benefit)

Waiver Benefits

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

- Elderly Waiver
- Person with Disabilities Waiver
- HIV/AIDS Waiver
- Traumatic Brain Injury Waiver
- Supportive Living Facility (SLF) Waiver

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

Long Term Services & Supports (Dependent on Waiver Eligibility)

Adaptive Equipment

Devices, controls, or appliances, specified in the plan of care, to improve ability to perform activities of daily living

Adult Day Service

Community-based social services offering a variety of social, recreational, health, nutrition, and related supports in a communal setting during daytime hours

Assisted Living

Apartment-style housing with the following menu of services:

- Intermittent nursing services
- Meals and snacks
- Medication oversight
- Personal care
- Well-being check
- Health promotion and exercise programming
- Maintenance
- Social/recreational programming
- 24-hour response/ security staff
- Emergency call system
- Laundry
- Housekeeping
- Ancillary services

Personal Emergency Response System

Electronic equipment, linked to a telephone line, providing 24-hour access to help in an emergency

Environmental Accessibility Adaptions

Physical modifications to the home setting in order to support individual health, welfare, and safety needs

(Adaptions intended for some other purpose not included)

Home-Delivered Meals

Meal services consisting of home-delivered meals for lunch and/or dinner service

Nursing—Skilled

Nursing services for short-term acute healing needs, intended as an alternative to hospitalization or nursing facility stay

Nursing—Intermediate

Long-term nursing services to provide medical expertise in the home to assist in the treatment of chronic conditions

Home Health Aide

In-home help with basic health needs under supervision of medical professional

Homemaker

In-home caregiver providing help with activities of daily living such as meal preparation, shopping, light housekeeping, and laundry

Personal Assistant

In-home caregiver hired directly by a member to provide help with activities of daily living such as meal preparation, shopping, light housekeeping, and laundry

(These can include direct caregivers such as RNs, LPNs, and Home Health Aides.)

Rehabilitation Services

Physical, occupational, and speech therapy services covered with waiver

Respite

Caregiver services intended to relieve unpaid family members who are assisting the member

Supported Employment

Services intended to allow member to remain in the workforce, including supervision and training

Supportive Living Facility

Assisted living residence providing support services to meet members' needs to remain independent, including: housekeeping, personal care, medication oversight, shopping, meals, and social programs

Day Habilitation

Independent living skills, including self-help management, socialization, and building adaptiveness, to help member gain maximum functional level

Prevocational Services

Work training designed to help skill-building to join the general workforce. Includes attendance, task completion, problem-solving, and safety

Waiver Services Grid

Service	Elderly	Disabled	HIV/AIDS	Brain Injury	SLF Waiver
Adult Day Service	✓	✓	✓	✓	
Adult Day Service Transportation	✓	✓	✓	✓	
Assisted Living					✓
Behavioral Services				✓	
Day Habilitation				✓	
Emergency Home Response System	✓	✓	✓	✓	
Environmental Modification		✓	✓	✓	
Supported Employment				✓	
Home-Delivered Meals		✓	✓	✓	
Home Health Aide		✓	✓	✓	
Homemaker	✓	✓	✓	✓	
Nursing—Intermittent		✓	✓	✓	
Nursing—Skilled		✓	✓	✓	
Occupational Therapy	✓	✓	✓		
Personal Assistant	✓	✓	✓		
Physical Therapy	✓	✓	✓		
Respite	✓	✓	✓		
Specialized Medical Equipment/ Supplies	✓	✓	✓		
Speech Therapy	✓	✓	✓		
Prevocational Services			✓		

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

Over-the-Counter (OTC) Drugs

As a member, you receive a fixed dollar amount each month to spend on eligible OTC products that you use for medical purposes. Only you can use your benefit. OTC drugs and products are intended for your use only. You can order up to $10 of eligible OTC items each month from our OTC catalog. Any unused amount does not carry over to the next month. We will not reimburse you for purchased OTC items.

Prescription drugs are not covered under the MLTSS program. To get prescription drugs, contact your Medicare/Medicaid plan to learn what is available to you.

Non-Covered Services

know what services are *not* covered.

Below are the care services that are not covered by your plan. Please know, this is not a complete list. If you have questions about what services are covered, call Member Services.

- Elective cosmetic surgery
- Experimental and/or investigational drugs, procedures, or equipment
- Infertility care and medicine for erectile dysfunction
- Services provided in an Intermediate Care Facility for the developmentally disabled
- Services provided through local education agencies
- Any service that is not medically necessary
- Hospice*
- Surgery
- Outpatient care
- Emergency and urgent care/hospital services
- Family planning, birth control, obstetric and maternity care, sterilization, abortions
- Physician services
- Dental services
- Optometric services
- Podiatric services
- Chiropractic services
- Physician psychiatric services
- Development therapy, orientation and mobility services (waivers)
- DSCC counseling/ fragile children
- DCFS rehab option services
- Physical therapy, occupational therapy, and speech therapy services
- Audiology services
- Anesthesia services
- Midwife services
- Genetic counseling
- General clinic services
- Inpatient psychiatric clinic services
- Clinic services (physical rehabilitation)
- Mental health clinic option services
- Pharmacy services
- Clinical laboratory services
- Portable X-ray services
- Optical supplies
- Medical supplies
- Emergency ambulance transportation
- Nurse practitioner services
- Social work services
- Psychologist services
- Subacute care program
- SOPF—MI
- LTC—developmental training (levels I–III)
- LTC—MR recipient between ages 21–65; inappropriately placed
- Transplants
- Genetic counseling
- Medical equipment/ prosthetic devices
- LTC—NF skilled (partial Medicare coverage)

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

MLTSS members will receive services such as hospitalization, provider visits, therapies, prescriptions, laboratory and X-ray services, medical supplies, and more through their Medicaid or Medicare plans (including Medicare fee-for-service, Medicare Part D, or Medicare Advantage). Please contact your plan administrator for more information.

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.

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
- Durable medical equipment (DME) vendors
- Family Case Management sites
- 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 are going
- Additional riders and their ages
- The name of your provider
- Your appointment date and time
- The address and phone number where you will be picked up
- 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.

24/7 Nurse Advice Line

we're always here to *help*.

The 24/7 Nurse Advice Line is a free, confidential service where you can get medical guidance and support from a nurse any time you need it. You can reach the 24/7 Nurse Advice Line by calling **866-821-2308**. A nurse is available to all members 24 hours a day, 7 days a week.

The nurse you talk to will help you understand if you or a family member need 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.

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

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

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

Cost Sharing

here's what to *do* if you get a bill or statement.

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

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

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

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

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

Care Coordination

get *personalized* support to help manage your care.

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

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

What is care coordination?

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

The goals of care coordination are to:

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

How can care coordination help you?

Your Care Coordinator will:

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

Health Management Programs

benefit from special *support*.

We want all of our members to be able to take control of their health. That's why we offer special healthcare programs to help members with specific concerns.

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.

Complex Case Management Program

We know it can be difficult to manage chronic medical conditions. The Complex Case Management (CCM) program is here to help.

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 CCM program if you have asthma, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, or hypertension. You can also sign up by calling Member Services at **866-821-2308**.

Monitor your blood pressure at home.

Meridian has a program to manage high blood pressure. Eligible members can check their own blood pressure at home. A smartphone app will share the readings with providers.

To learn more, call Member Services at **866-821-2308**.

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. The person you pick should be someone you trust, like a family member or friend. The person you pick will be able to:

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

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

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

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 providers what you want to do in case your heart or breathing stops.

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

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. If you need help filing a grievance, call your Care Coordinator or Member Services at **866-821-2308**.

Meridian takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you 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 **866-821-2308**. You can also file your grievance in writing via mail or fax:

Meridian
Attn: Grievance Dept.
PO Box 10353
Van Nuys, CA 90410-0353
Fax: 833-669-1734

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved, and details about what happened. Be sure to include your name and your member ID number.

You can ask us to help you file your grievance by calling Member Services at **866-821-2308**.

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are 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 acknowledge your grievance by sending you or your representative a letter within 48 hours of receiving the grievance. The resolution time frame for a grievance can take up to 90 calendar days.

Appeals

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

This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right 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 **866-821-2308**.
2. Mail or fax your written appeal request to:

Meridian
Attn: Meridian Appeals Dept.
PO Box 716
Elk Grove Village, IL 60009
Fax: 833-383-1503

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

Can someone help you with the appeal process?

You have several options for help. You may:

- Ask someone you know to help represent you. This could be your 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 **866-821-2308**.

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

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

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish
- Visit **abe.illinois.gov/abe/access/appeals** to set up an ABE Appeals Account and submit a State Fair Hearing 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**

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 Hearings 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: Meridian Appeals Dept.
PO Box 716
Elk Grove Village, IL 60009

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 **866-821-2308**. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Meridian
Attn: Meridian Appeals Dept.
PO Box 716
Elk Grove Village, IL 60009
Fax: 833-669-1734

What happens next?

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

Other important information

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

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

You can call Meridian at any time if you have a question about your benefits, providers, or any service you have asked for or received. You can call Member Services at **866-821-2308**. We are open Monday through Friday, 8:00 a.m. to 5:00 p.m. When a Meridian representative answers the phone, he or she will greet you by telling you his or her name, title, and company. All calls you make are toll-free.

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

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

Rights & Responsibilities

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

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

Your rights:

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

- Choose your own primary care provider (PCP); you can change your PCP at any time
- 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

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

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.

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

Reporting abuse, neglect, exploitation, or unusual incidents

If you believe you are a victim of abuse, neglect, or exploitation, you should report this right away. You can call your Care Coordinator or Member Services at **866-821-2308** (TTY: **711**). Meridian must follow up with you to provide resources and ensure your safety.

You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept confidential. Anonymous reports are accepted.

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

Nursing Home Hotline: 800-252-4343

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

Supportive Living Program Complaint Hotline: 844-528-8444

Adult Protective Services: 866-800-1409 (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. You can also call Member Services at **866-821-2308** (TTY: **711**) to report your incident.

Definitions

here are *definitions* of common plan terms.

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

Copay 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 (DME) 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 or devices 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, 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 Member Services at **866-821-2308** (TTY: **711**).

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 (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384
Tampa, FL 33631
855-577-8234 (TTY: **711**)
FAX: 866-388-1769
SM_Section1557Coord@centene.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 1557 Coordinator is available to help you.

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 hhs.gov/ocr/complaints/index.html.

This notice is available at **ILmeridian.com**.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 **866-821-2308** for a printed copy.

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

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

Treatment. We may disclose medical information about you for the purpose of coordinating your 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 **866-821-2308** (TTY: **711**). 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

866-821-2308
(TTY: 711)

Monday–Friday,
8:00 a.m. to 5:00 p.m.

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Meridian Member Services:
866-821-2308 (TTY/TDD: 711)

member.ILmeridian.com

Revised: 10/29/2024
State Approved: 10/29/2024