Meridian Medicare-Medicaid Plan (MMP) *Member Handbook*

January 1, 2025 – December 31, 2025

Your Health and Drug Coverage under the Meridian Medicare-Medicaid Plan (MMP)

Member Handbook Introduction

This handbook tells you about your coverage for the time you are enrolled with Meridian Medicare-Medicaid Plan (MMP) through December 31, 2025. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports include long-term care and home and community-based waivers (HCBS). HCBS waivers can offer services that will help you stay in your home and community. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

Meridian Medicare-Medicaid Plan (MMP) plan is offered by Meridian Health Plan of Illinois, Inc. When this *Member Handbook* says “we,” “us,” or “our,” it means Meridian Health Plan of Illinois, Inc. When it says “the plan” or “our plan,” it means Meridian Medicare-Medicaid Plan (MMP).

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We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at **1-855-580-1689 (TTY: 711)**. Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Someone that speaks English/Language can help you. This is a free service.

Contamos con los servicios gratuitos de un intérprete para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para solicitar un intérprete, llámenos al **1-855-580-1689 (TTY: 711)**. El horario de atención es de lunes a viernes, de 8 a.m. a 8 p.m. Es posible que los fines de semana y los días festivos estatales o federales le pidan que deje un mensaje. Lo llamaremos el siguiente día hábil. Alguien que hable español puede ayudarlo. Este es un servicio gratuito.

我们提供免费的口译服务，为您解答您对我们的健康或药物计划可能存有的疑问。要获得口译员，致电 **1-855-580-1689 (TTY: 711)** 联系我们即可。我们的工作时间：周一至周五早上 8 点至晚上 8 点。周末和州/联邦节假日请留言。我们将在下一个工作日内给您回电。会讲中文（普通话）的人员可以为您提供帮助。这项服务免费。

我們提供免費的口譯服務，可解答您對我們的健康或藥物計劃可能有的任何疑問。如需口譯員服務，請致電 **1-855-580-1689 (TTY: 711)**。服務時間為週一至週五，上午 8 點至晚上 8 點。週末和州或聯邦假日，可能會要求您留言。我們將在下一個工作日內回電給您。會說廣東話的人員可以幫助您。此為免費服務。

May mga libre kaming serbisyo sa pagsasalin para sagutin ang anumang posibleng tanong ninyo tungkol sa aming planong pangkalusugan o plano sa gamot. Para makakuha ng tagasalin, tawagan lang kami sa **1-855-580-1689 (TTY: 711)**. Ang mga oras ay 8 a.m. hanggang 8 p.m. mula Lunes hanggang Biyernes. Kapag Sabado at Linggo at mga pang-estado o pederal na holiday, posibleng hilingin sa inyo na mag-iwan ng mensahe. Tatawagan kayo sa susunod na araw na may pasok. May nagsasalita ng Tagalog na makakatulong sa inyo. Isa itong libreng serbisyo.

Nous disposons de services d’interprétation gratuits pour répondre à toutes les questions que vous vous posez sur notre régime de santé ou de médicaments. Pour obtenir les services d’un interprète, il vous suffit de nous appeler au **1-855-580-1689 (TTY : 711)**. Les heures d’ouverture sont du lundi au vendredi, de 8

heures à 20 heures. Le week-end et les jours fériés nationaux ou fédéraux, il se peut que l'on vous demande de laisser un message. Vous serez rappelé le jour ouvrable suivant. Une personne parlant français pourra vous aider. Ce service est gratuit.

Chúng tôi có dịch vụ thông dịch miễn phí để trả lời mọi câu hỏi quý vị có thể có về chương trình sức khỏe hoặc thuốc của chúng tôi. Để được hỗ trợ thông dịch, chỉ cần gọi cho chúng tôi theo số **1-855-580-1689 (TTY: 711)**. Giờ làm việc là từ Thứ Hai đến Thứ Sáu, từ 8 a.m. đến 8 p.m. Vào cuối tuần và ngày lễ của tiểu bang hoặc liên bang, quý vị có thể được yêu cầu để lại tin nhắn. Chúng tôi sẽ trả lời cuộc gọi của quý vị vào ngày làm việc tiếp theo. Nhân viên nói tiếng Việt có thể trợ giúp quý vị. Đây là dịch vụ miễn phí.

Wir bieten Ihnen einen kostenlosen Dolmetschservice, wenn Sie Fragen zu unseren Gesundheits- oder Medikamentenplänen haben. Um einen Dolmetscher in Anspruch zu nehmen, rufen Sie uns unter folgender Telefonnummer an: **1-855-580-1689 (TTY: 711)**. Wir sind montags bis freitags von 8 bis 20 Uhr erreichbar. An Wochenenden und an Feiertagen werden Sie möglicherweise aufgefordert, eine Nachricht zu hinterlassen. Wir rufen Sie am nächsten Werktag zurück. Ein deutschsprachiger Mitarbeiter wird Ihnen behilflich sein. Dieser Service ist kostenlos.

당사의 건강 또는 의약품 플랜과 관련해서 물어볼 수 있는 모든 질문에 답변하기 위한 무료 통역 서비스가 있습니다. 통역사가 필요한 경우, **1-855-580-1689(TTY: 711)**번으로 연락해 주십시오. 월요일부터 금요일까지 오전 8시~오후 8시에 문의하십시오. 주말 및 주 또는 연방 공휴일에는 메시지를 남길 것을 요청할 수 있습니다. 그러면 다음 영업일에 전화드리겠습니다. 한국어를 구사하는 통역사가 도움을 드릴 수 있습니다. 통역 서비스는 무료로 제공됩니다.

Если у вас возникли какие-либо вопросы о нашем плане медицинского страхования или плане с покрытием лекарственных препаратов, вам доступны бесплатные услуги переводчика. Если вам нужен переводчик, просто позвоните нам по номеру 1-855-580-1689 (TTY: 711). Часы работы: с понедельника по пятницу с 8 a.m. до 8 p.m. В выходные дни и государственные праздники вас могут попросить оставить сообщение. Вам перезвонят на следующий рабочий день. Вам окажет помощь сотрудник, говорящий на русском языке. Данная услуга бесплатна.

نوفّر خدمات ترجمة فورية مجانية إذا أردت التحدث إلينا عن خطة الصحة أو الدواء الخاصة بنا. للوصول إلى خدمة الترجمة الفورية، ما عليك سوى الاتصال بنا على الرقم **1-855-580-1689 (TTY: 711)**. من الاثنين إلى الجمعة، من الساعة 8 صباحًا وحتى الساعة 8 مساءً يُطلب منك في عطلات نهاية الأسبوع وفي أيام الإجازات الرسمية أو إجازات الولاية، وسنعاود الاتصال بك خلال اليوم العمل التالي. نحن أسعداء لتحدث العربية و هذه الخدمة مجانية.

If you have questions, please call Meridian Medicare-Medicaid Plan (MMP) at 1-855-580-1689 (TTY: 711). Hours are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free. **For more information**, visit mmp.ILmeridian.com.

Sono disponibili servizi di interpretariato gratuiti per rispondere a qualsiasi domanda possa avere in merito al nostro piano farmacologico o sanitario. Per usufruire di un interprete, è sufficiente contattare il numero **1-855-580-1689 (TTY: 711)** dal lunedì al venerdì dalle 8:00 alle 20:00. Nei fine settimana e nei giorni festivi statali o federali potrebbe essere necessario lasciare un messaggio. La ricontatteremo entro il giorno lavorativo successivo. Qualcuno la assisterà in lingua italiana. È un servizio gratuito.

Temos serviços de intérprete gratuitos para responder a quaisquer dúvidas que possa ter sobre o nosso plano de saúde ou medicação. Para obter um intérprete, contacte-nos através do número **1-855-580-1689 (TTY: 711)**. O horário é de segunda-feira a sexta-feira, das 08:00 às 20:00. Se ligar num fim de semana ou num feriado estadual ou federal, poderá ter de deixar mensagem. A sua chamada será devolvida no próximo dia útil. Um falante de português poderá ajudá-lo. Este serviço é gratuito.

Nou gen sèvis tradiksyon nan bouch gratis pou reponn nenpòt kesyon ou gendwa vle poze konsènan sante w ak plan medikaman w lan. Pou jwenn yon entèprèt pou tradui pou w, annik rele nou nan **1-855-580-1689 (TTY: 711)**. Orè a se Lendi pou Vandredi, 8 a.m. jiska 8 p.m. Nan wikenn epi pandan jou ferye Eta a oswa federal, yo gendwa mande w pou w kite yon mesaj. Y ap rele w nan landemen si biwo yo louvri. Yon moun ki pale Kreyòl Ayisyen pral ede w. Sèvis sa a gratis.

Oferujemy bezpłatną usługę tłumaczenia ustnego, która pomoże Państwu uzyskać odpowiedzi na ewentualne pytania dotyczące naszego planu leczenia lub planu refundacji leków. Aby skorzystać z usługi tłumaczenia ustnego, wystarczy zadzwonić pod numer **1-855-580-1689 (TTY: 711)** od poniedziałku do piątku w godzinach od 8:00 do 20:00. W weekendy i święta konieczne może być pozostawienie wiadomości. Oddzwonimy w następnym dniu roboczym. Zapewni to Państwu pomoc osoby mówiącej po polsku. Usługa ta jest bezpłatna.

हमारे स्वास्थ्य या ड्रग प्लान के बारे में आपके किसी भी सवाल का जवाब देने के लिए, हम मुफ़्त में दुभाषिया सेवाएं देते हैं। दुभाषिया सेवा पाने के लिए, बस हमें **1-855-580-1689 (TTY: 711)**. पर कॉल करें। सोमवार से शुक्रवार कार्य का समय सुबह 8 बजे से लेकर रात 8 बजे तक है। सप्ताहांत और राज्य या संघीय अवकाशों पर, आपसे संदेश छोड़ने के लिए कहा जा सकता है। आपके कॉल का जवाब अगले व्यावसायिक दिन के अंदर दिया जाएगा। हिंदी में बात करने वाला सहायक आपकी मदद करेगा। यह एक निःशुल्क सेवा है।

弊社の健康や薬剤計画についてご質問がある場合は、無料の通訳サービスをご利用いただけます。通訳を利用するには、**1-855-580-1689**（**TTY：711**）にお電話ください。対応時間は月曜日～金曜日の午前8時～午後8時です。対応時間後、または週末および祝日はボイスメッセージを残してください。次の対応時間内に折り返しお電話いたします。日本語の通訳担当者が対応します。これは無料のサービスです。

Διαθέτουμε δωρεάν υπηρεσίες διερμηνέων για να απαντήσουμε σε τυχόν ερωτήσεις που μπορεί να έχετε σχετικά με το πρόγραμμα υγείας ή το πρόγραμμα φαρμάκων. Για να βρείτε διερμηνέα, απλά καλέστε μας στο **1-855-580-1689 (TTY: 711)** από τις 8 π.μ. έως τις 8 μ.μ., από Δευτέρα έως Παρασκευή. Μετά το πέρας του εργάσιμου ωραρίου, τα Σαββατοκύριακα και τις αργίες, ενδέχεται να σας ζητηθεί να αφήσετε μήνυμα. Η κλήση σας θα απαντηθεί εντός της επόμενης εργάσιμης ημέρας. Κάποιος που μιλάει ελληνικά μπορεί να σας βοηθήσει. Πρόκειται για δωρεάν υπηρεσία.

અમારા હેલ્થ અથવા ડ્રગ પ્લાન વિશે તમને હોઈ શકે તેવા કોઈ પણ પ્રશ્નોના જવાબ આપવા માટે અમારી પાસે મફત દુભાષિયાની સેવાઓ રહેલી છે. દુભાષિયો મેળવવા માટે, બસ અમને **1-855-580-1689 (TTY: 711)** પર કોલ કરો. કોલ કરવાનો સમય, સોમવારથી શુક્રવાર સુધી, સવારે 8 વાગ્યાથી રાત્રે 8 વાગ્યા સુધીનો છે. શનિ-રવિએ અને રાજ્યની કે ફેડરલ રજાઓ પર, તમને મેસેજ આપી રાખવા માટે કહેવામાં આવી શકે છે. તમારા કોલ પર વળતો કોલ કામકાજના આગલા દિવસની અંદર કરવામાં આવશે. ગુજરાતી બોલતી કોઈ વ્યક્તિ તમારી મદદ કરી શકે છે. આ એક મફત સેવા છે.

ہمارے صحت یا دوائی پلان کے بارے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت ترجمہ سروس موجود ہے۔ ترجمہ کرنے والے کو حاصل کرنے کے لیے بس ہمیں **1-855-580-1689 (TTY: 711)** پر کال کریں۔ کال کرنے کا وقت پیر سے جمعہ صبح 8 بجے سے رات 8 بجے تک ہے۔ ہفتہ اور اتوار کو اور وفاقی یا ریاستی تعطیلات پر، آپ سے پیغام چھوڑنے کو کہا جا سکتا ہے۔ آپ کے کال کا جواب اگلے کاروباری دن میں دیا جائے گا۔ آپ کی مدد کرنے والا شخص اردو بولتا ہے۔ یہ ایک مفت سروس ہے۔

If you have questions, please call Meridian Medicare-Medicaid Plan (MMP) at 1-855-580-1689 (TTY: 711). Hours are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free. **For more information**, visit mmp.ILmeridian.com.

This document is available for free in Spanish.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-855-580-1689 (TTY: 711), Representatives are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

To make a standing request, change a standing request or make a one-time request for materials in a language other than English or in an alternate format, please call Meridian at 1-855-580-1689 (TTY users should call 711). We will document your choice. Hours are Monday-Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

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Disclaimers

- Meridian Medicare-Medicaid Plan (MMP) is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees.
- Out-of-network/non-contracted providers are under no obligation to treat Meridian members, except in emergency situations. Please call our Member Services number or see your Member Handbook for more information, including the cost-sharing that applies to out-of-network services.
- Coverage under Meridian Medicare-Medicaid Plan (MMP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Meridian Medicare-Medicaid Plan (MMP), a health plan that covers all your Medicare and Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from Meridian. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Welcome to Meridian Medicare-Medicaid Plan (MMP)

Meridian is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Meridian was approved by the State of Illinois and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Medicare-Medicaid Alignment Initiative.

The Medicare-Medicaid Alignment Initiative is a demonstration program jointly run by Illinois and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Illinois must approve Meridian each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the State of Illinois approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services will not be affected.

C. Advantages of this plan

You will now get all your covered Medicare and Medicaid services from Meridian, including prescription drugs. **You do not pay extra to join this health plan.**

Meridian will help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care coordinator. This is a person who works with you, with Meridian, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care coordinator.
- The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
    - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
    - Your care team will make sure your test results are shared with all your doctors and other providers.

D. Meridian's service area

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

Only people who live in our service area can get Meridian.

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8, Section I for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as:

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
- you have both Medicare Part A and Medicare Part B, **and**
- you are eligible for Medicaid, **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are age 21 and older at the time of enrollment, **and**
- you are enrolled in the Medicaid Aid to the Aged, Blind and Disabled category of assistance, **and**
- if you meet all other Demonstration criteria and are in one of the following Medicaid 1915(c) waivers:
    - persons who are elderly;
    - persons with disabilities;

- persons with HIV/AIDS;
- persons with brain injury; **or**
- persons residing in Supportive Living Facilities.
- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

F. What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment within the first 90 days. You will receive a call from our Care Management department to complete the health risk assessment. Your assigned care coordinator will then complete an individualized care plan with you.

If this is your first time in a Medicare-Medicaid Plan, you can keep using the doctors you use now for 180 days. **If you changed to Meridian from a different Medicare-Medicaid Plan**, you can keep using the doctors you use now for 90 days. When completing the Health Risk Screening/Assessment you will be asked the names and contact information of your doctors. Care coordinators will then be able to verify if your doctors are in network or out-of-network with our health plan.

After 90 or 180 days depending on your continuity of care period, you will need to use doctors and other providers in the Meridian network. A network provider is a provider who works with the health plan. Refer to Chapter 3, Section D for more information on getting care.

G. Your care plan

Your care plan is the plan for what medical, behavioral, long-term supports, social and functional services you will get and how you will get them.

After your health risk assessment, your care team will meet with you to talk about what services you need and want. Together, you and your care team will make your care plan.

Every year, your care team will work with you to update your care plan if the services you need and want change.

If you are getting Home and Community-Based Waiver services, you will also have a service plan. The service plan lists the services you will get and how often you will get them. This service plan will become part of your overall care plan.

H. Meridian monthly plan premium

Meridian does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9, Section D or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also refer to the *Member Handbook* at mmp.ilmeridian.com/resources.html or download it from this website.

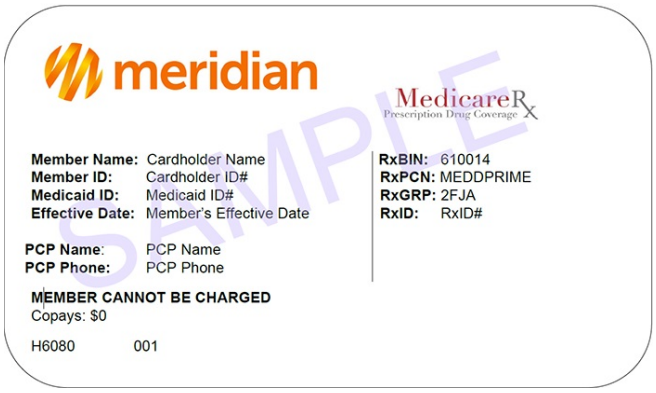
The contract is in effect for the months you are enrolled in Meridian between January 1, 2025, and December 31, 2025.

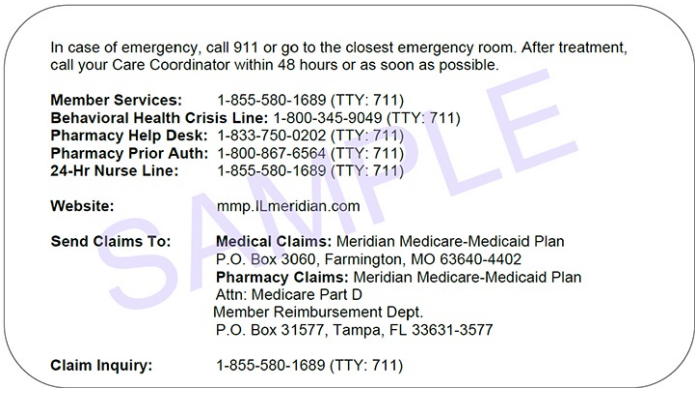
J. Other important information you will get from us

You should have already gotten a Meridian Member ID Card, a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

J1. Your Meridian Member ID Card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:





If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Meridian Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Meridian network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (refer to section F).

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at mmp.ilmeridian.com/member/benefits-coverage/tools-resources/provider-search.html or download it from this website.

The *Provider and Pharmacy Directory* lists the phone numbers, addresses, hours of operation and additional information for all of our in-network providers and pharmacies.

Definition of network providers

- Meridian's network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid; and
    - Long-term supports and services, including adult day service, assisted living and day habilitation, home delivered meals, home health aide, home modifications, homemaker services, nursing services, personal assistant, personal emergency response system, respite care, specialized durable medical equipment and supplies, and therapies.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free. You can also refer to the *Provider and Pharmacy Directory* at mmp.ilmeridian.com/member/benefits-coverage/tools-resources/provider-search.html or download it from this website. Both Member Services and Meridian's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "*Drug List*" for short. It tells which prescription drugs are covered by Meridian.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5, Section C for more information on these rules and restrictions.

Each year, we will send you information about how to access a copy of the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit mmp.ilmeridian.com/pharmacy/formulary.html or call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

J4. The *Explanation of Benefits*

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or EOB).

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs

during the month. The EOB has more information about the drugs you take. Chapter 6, Section A gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your enrollee profile up to date

You can keep your enrollee profile up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your enrollee profile to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- changes to your name, your address, or your phone number
- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- any liability claims, such as claims from an automobile accident
- admission to a nursing home or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part of or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any information changes, please let us know by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

K1. Privacy of personal health information (PHI)

The information in your enrollee profile may include personal health information (PHI). Laws require that we keep your medical records and PHI private. We make sure that your health information is protected.

Meridian is working with the State of Illinois to stop new HIV cases. The Illinois Department of Public Health is sharing HIV data they have with IL Medicaid and IL Medicaid Managed Care Organizations

to have better care for people living with HIV. Name, date of birth, SSN, HIV status and other information is being shared safely and securely for all Medicaid members.

For more information about how we protect your PHI, refer to Chapter 8, Section C1.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Meridian and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. How to contact Meridian Medicare-Medicaid Plan (MMP) Member Services

CALL	1-855-580-1689 This call is free. Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.
FAX	1-833-376-0586
WRITE	Meridian Medicare-Medicaid Plan (MMP) 1333 Burr Ridge Parkway, Suite 100 Burr Ridge, IL 60527
WEBSITE	mmp.ILmeridian.com

A1. When to contact Member Services

- questions about the plan
- questions about claims, billing or Meridian Member ID Cards
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we will pay for your health services.
  - Call us if you have questions about a coverage decision about health care.

- To learn more about coverage decisions, refer to Chapter 9, Section D.

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
  - To learn more about making an appeal, refer to Chapter 9, Section D.
- complaints about your health care
  - You can make a complaint about us or any provider – including a non-network or network provider. A network provider is a provider who works with the health plan. You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received (refer to Section F below).
  - If your complaint is about a coverage decision about your health care, you can make an appeal. (Refer to the section above Section A1).
  - You can send a complaint about Meridian right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, refer to Chapter 9, Section J.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs, **or**
    - the amount we will pay for your drugs.
  - This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to Chapter 9, Section F4.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.

    To start your appeal, you, your doctor or other provider, or your representative must contact us.

Appeals for Part D Drugs

You can call us at 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Appeals for Part D Drugs can also be sent in writing to the address below:

Meridian Medicare-Medicaid Plan (MMP)
Medicare Part D Appeals
PO Box 31383
Tampa, FL 33631-3383

You can also send us a fax at: 1-866-388-1766

Appeals for Part B Drugs

You can call us at 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Appeals for Part B Drugs can also be sent in writing to the address below:

Meridian Medicare-Medicaid Plan (MMP)
Appeals & Grievances
Medicare Operations
P.O. Box 10450
Van Nuys, CA 91410-0450

You can also send us a fax at: 1-844-273-2671

- For more on making an appeal about your prescription drugs, refer to Chapter 9, Section F5.

- complaints about your drugs
  - You can make a complaint about us or a pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above A1.)
  - You can send a complaint about Meridian right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

- For more on making a complaint about your prescription drugs, refer to Chapter 9, Section J.

- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7, Section A.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section F4 for more on appeals.

B. How to contact your care coordinator

CALL	1-855-580-1689 This call is free. Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.
WRITE	Meridian Medicare-Medicaid Plan (MMP) 1333 Burr Ridge Parkway, Suite 100 Burr Ridge, IL 60527
WEBSITE	mmp.ILmeridian.com

B1. When to contact your care coordinator

- questions about your health care
- questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)
- If your provider or care coordinator thinks you may be eligible for long-term care or additional supports and services to keep you in your home, they will refer you to an agency that will decide if you are eligible for those services.

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- skilled nursing care
- personal Assistant
- homemaker
- adult Day Care
- emergency Home Response System
- physical therapy
- occupational therapy
- speech therapy
- home health care
- habilitation-day
- home delivered meals
- home health aid
- home modifications
- nursing services
- respite care
- specialized durable medical equipment and supplies

C. How to contact the Nurse Advice Call Line

The Nurse Advice Call Line is a toll-free advice line available to you 24 hours a day, 7 days a week, 365 days a year. By calling, you can get medical guidance and support from a nurse. If you are having a medical emergency, please call 911.

CALL	1-855-580-1689 This call is free. 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, 365 days a year.

C1. When to contact the Nurse Advice Call Line

- questions about your health care

D. How to contact the Behavioral Health Crisis Line

CALL	1-800-345-9049 This call is free. 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, 365 days a year.

D1. When to contact the Behavioral Health Crisis Line

The CARES Line (Crisis and Referral Entry Service) offers support, guidance and counseling options. You should contact the CARES Line if you need assistance in scheduling emergency behavioral health appointments, are having suicidal thoughts or are having symptoms of mental health illnesses. Our CARES Line staff can help you get the services you need.

- questions about behavioral health services
- questions about substance use disorder services

E. How to contact the Senior Health Insurance Program (SHIP)

The Senior Health Insurance Program (SHIP) gives free health insurance counseling to people with Medicare. SHIP is not connected with any insurance company or health plan.

CALL	1-800-252-8966 Monday-Friday 8:30 a.m. - 5 p.m. The call is free.
TTY	1-888-206-1327 Monday-Friday 8:30 a.m. - 5 p.m. The call is free.
WRITE	Senior Health Insurance Program Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271
EMAIL	AGING.SHIP@illinois.gov
WEBSITE	www2.illinois.gov/aging/ship/Pages/default.aspx

E1. When to contact the SHIP

- questions about your Medicare health insurance
    - SHIP counselors can answer your questions about changing to a new plan and help you:
        - understand your rights,
        - understand your plan choices,
        - answer your questions about changing to a new plan,
        - make complaints about your health care or treatment, **and**
        - straighten out problems with your bills.

F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called a Livanta LLC/BFCC-QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta LLC/BFCC-QIO is not connected with our plan.

CALL	1-888-524-9900
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta LLC/BFCC-QIO 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701-1105
EMAIL	communications@Livanta.com
WEBSITE	www.livantaqio.cms.gov/en

F1. When to contact Livanta LLC/BFCC-QIO

- questions about your health care
    - You can make a complaint about the care you got if you:
        - have a problem with the quality of care,
        - think your hospital stay is ending too soon, **or**
        - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about your Medicaid eligibility, call the Illinois Department of Human Services Customer Help Line.

CALL	1-800-843-6154 Monday-Friday 8 a.m. – 5 p.m. The call is free.
TTY	1-866-324-5553 Monday-Friday 8 a.m. – 5 p.m. The call is free.
EMAIL	DHS.WebBits@illinois.gov
WEBSITE	www.dhs.state.il.us

I. How to contact the Illinois Health Benefits Hotline

The Illinois Department of Healthcare and Family Services Health Benefits Hotline provides general information about Medicaid benefits.

CALL	1-800-226-0768 Monday-Friday 8 a.m. – 4:30 p.m. The call is free.
TTY	1-877-204-1012 Monday-Friday 8 a.m. – 4:30 p.m. The call is free.
WEBSITE	www.hfs.illinois.gov This is the official website for Medicaid. It gives you up-to-date information about Medicaid.

J. How to contact the Illinois Home Care Ombudsman Program

The Illinois Home Care Ombudsman Program is an ombudsman program that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. They also can help you file a complaint or an appeal with our plan. The Illinois Home Care Ombudsman is not connected with any insurance company or health plan. Their services are free.

CALL	1-800-252-8966 Monday-Friday 8:30 a.m. – 5 p.m. The call is free.
TTY	1-888-206-1327 Monday-Friday 8:30 a.m. – 5 p.m. The call is free.
WRITE	Home Care Ombudsman Program Illinois Department on Aging One Natural Resources Way, Suite 100 Springfield, IL 62702-1271
EMAIL	Aging.HCOProgram@illinois.gov
WEBSITE	www.illinois.gov/aging/programs/LTCOmbudsman/Pages/The-Home-Care-Ombudsman-Program.aspx

K. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it may help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January- December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. "Extra Help" form Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, regardless of income level, and plans with drug coverage must offer this payment option. Contact us at the phone number at the bottom of the page or visit www.medicare.gov to find out if this payment option is right for you.

L. Other resources

Contact the Illinois Department on Aging

Contact the Senior HelpLine toll-free or via email about the Department's programs and services for older adults and persons with disabilities. In most instances, when looking for assistance with specific programs, you will be referred to a local office in the area you live.

CALL	1-800-252-8966 Monday-Friday 8:30 a.m. – 5:00 p.m. The call is free.
TTY	1-888-206-1327 Monday-Friday 8:30 a.m. – 5:00 p.m. The call is free.
EMAIL	aging.ilsenior@illinois.gov

Chapter 3: Using the plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Meridian Medicare-Medicaid Plan (MMP). It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, Section D.

Providers are doctors, nurses, specialists and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

Meridian covers all services covered by Medicare and Medicaid. This includes medical, behavioral health, and long-term services and supports.

Meridian will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D of this handbook).
- The care must be **medically necessary.** Medically necessary means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules. Medically necessary refers to all covered services that are within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of disease, illness or injury.
- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another doctor**.** As a plan member, you must choose a network provider to be your PCP.

- In most cases, your network PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Meridian may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. To learn more about referrals, refer to Section D1.
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to Section I.
  - To learn more about choosing a PCP, refer Section D1.
- **NOTE:** If this is your first time in a Medicare-Medicaid Plan, you may continue to use your current providers for the first 180 days with our plan, at no cost, if they are not a part of our network. If you changed to Meridian from a different Medicare-Medicaid Plan, you may continue to use your current providers for the first 90 days with our plan, at no cost, if they are not a part of our network. During the transition time, our care coordinator will contact you to help you find providers in our network. After that time, we will no longer cover your care if you continue to use out-of-network providers.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section I.
  - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care at no cost to you. Generally, if you need care from an out-of-network provider, you will need to get a prior authorization (prior approval) from the plan. To learn about getting approval to use an out-of-network provider, refer to Section D.
  - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
  - When you first join the plan, you can continue using the providers you use now for 90 to 180 days depending on your continuity of care period. You will need to see doctors and other providers in the Meridian network after this period.

C. Information about your care coordinator

C1. What a care coordinator is

Your care coordinator's goal is to help you address goals for your health while coordinating your services to help you have a better quality of life. This person helps manage your care by coordinating with all of your providers to ensure that you receive the services and care you need. Your care coordinator will be your main point of contact at Meridian.

C2. How you can contact your care coordinator

You can contact your care coordinator at any time by calling 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

C3. How you can change your care coordinator

You can change your care coordinator at any time by calling 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

D. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of "PCP," and what a PCP does for you

- Your PCP can be a physician or nurse practitioner, or a physician assistant who meets state requirements and is trained to give you comprehensive medical care.

What types of providers may act as a PCP?

- Health professionals are eligible to provide services as PCPs in our plan when they practice and are licensed in the areas of family medicine, general practice, geriatrics, internal medicine and obstetrics/gynecology.
- If you see a health professional at a federally qualified health center (FQHC) for primary care services, you can continue to do so.
- Specialists who perform primary care functions, including specialists who provide primary care in FQHCs, rural health clinics, health departments and other similar community clinics can serve as your PCP.

What is the role of a PCP?

Your routine or basic care will be provided by your PCP.

What is the role of a PCP in coordinating covered services?

- "Coordinating" your services includes checking or consulting with other network providers and your plan about your care and how it is going.
- Your PCP can help you arrange or coordinate the rest of the covered services you get as a member of our plan. These services may include:
    - X-rays
    - Laboratory tests
    - Therapies
    - Specialist office visits
    - Hospital admissions
    - Follow-up care

- In order for you to see a specialist, you usually need to get approval from your PCP first (this is called getting a "referral"). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

What is the role of the PCP in making decisions about or obtaining prior authorization?

If you need certain types of covered services or supplies, your PCP will need to get prior authorization (prior approval) from us.

Your choice of PCP

Your relationship with your primary care provider (PCP) is an important one. We strongly recommend that you choose a PCP that is close to home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship easier. For a copy of the most current *Provider and Pharmacy Directory*, or to seek additional assistance in choosing a PCP, please contact Member Services. Once you have chosen your PCP, we recommend that you have all your medical records transferred to his or her office. This will provide your PCP access to your medical history and inform them of any existing health care conditions you may have.

Option to change your PCP

You may change your PCP for any reason, at any time during the year. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the new one you have now leaves our network.

If you change your PCP on or before the 10th of the month, you will be able to start seeing your new PCP immediately. If you change your PCP after the 10th of the month, you can begin seeing your new PCP on the 1st of the following month.

If your PCP leaves the network, you will receive a notification in the mail at least 30 days before the change takes place. We can help you find a new PCP if the one that you have now leaves our network.

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before using other providers. This approval is called a referral. You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or you need immediate care during the weekend).

  NOTE: Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to get services from Indian health providers, you may use these providers without a referral.
- You also have the right to see a gynecologist, dermatologist, an audiologist (for routine hearing exams), an optometrist (for routine vision exams) and a dentist (for preventative dental services) without a referral.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.

- Orthopedists care for patients with bone, joint, or muscle problems.

In some cases, you must get a referral from your PCP before you see a network specialist (there are a few exceptions described in Section D1 of this chapter). With a referral from your PCP, you can see any network provider and are not limited to a specific specialist or hospitals to which that PCP refers to. If you don't have a referral from your PCP before you receive services from a network specialist, you may have to pay for these services out-of-pocket. If you require follow-up care from an in-network specialist, you will need to coordinate with your PCP to obtain a referral (or referrals) for the additional visit(s).

Prior Authorization (prior approval) is a process that requires the PCP, specialist, other provider, or you (the member) to obtain approval for a procedure, service, drug, or piece of medical equipment from the health plan before it is performed or received. You should always discuss any procedures or services you believe you may need with your PCP and/or specialist. Typically, your PCP or specialist will obtain the prior authorization for you. Our team will make a decision on your prior authorization request and notify you and your provider of that decision. If you would like to request a prior authorization or referral or have any questions, please contact your care coordinator or Member Services at the numbers listed on the back of this booklet for more information. For more information about the services that require prior authorization or a referral, please refer to The Benefits Chart in Chapter 4, Section D.

D3. What to do when a network provider leaves our plan

A network provider you are using might leave our plan.

- If a network provider you are using leaves our plan, we will give you a 30-day notice when possible. If you do not select a new primary care provider, one will be selected for you. You can change your primary care provider at any time. If your provider leaves the network, you will receive a notification in the mail at least 30 days before the change takes place. You will also receive an updated ID card with your new PCP's name and phone number.

- If your provider leaves the plan's network, we will allow a transition period of 90 days from date of notice if you have an ongoing course of treatment or are in your third trimester of pregnancy, including postpartum care.

If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.

- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Except for emergency or urgently needed care, you must receive prior authorization from us before getting care from the out-of-network provider for services to be covered.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make an appeal of our decision. Refer to Chapter 9, Section D for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please contact Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

D4. How to get care from out-of-network providers

Most services will be provided by our network providers. If you need a service that cannot be provided within our network, for example, if you require specialized services that are not available from a network provider, we will pay for the cost of an out-of-network provider if the service has been approved in advance by the plan. If you go to providers who are not in our network without prior authorization (prior approval) from us, you may have to pay the bill. If you need services from an out-

of-network provider, you or the out-of-network provider should contact Member Services at the phone number on the back of this booklet prior to receiving the services. We will assist you and/or the provider in getting the necessary information to obtain prior authorization.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.
- A provider must be enrolled as an Illinois Medicaid Provider to get paid for any Medicaid services they provide to you.

E. How to get long-term services and supports (LTSS)

Meridian can assist in determining whether you may qualify for long-term services and supports (LTSS) and assist you with applying for LTSS funded services through State Medicaid Waivers. Please call Member Services at the phone number listed on the back cover of this booklet if you have any questions or concerns or would like to discuss LTSS services.

F. How to get behavioral health services

Behavioral health services support mental health and substance abuse treatment needs you may have. This can include emotional, social, educational, and recovery care, as well as more common psychiatric or medical care. Please contact Member Services at 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

G. How to get self-directed care

G1. What self-directed care is

Depending on your LTSS Waiver eligibility, you may be able to select a Personal Assistant (PA) service. Self-directed care allows you to choose who will provide personal care services to you. If you qualify, your care coordinator can assist you with signing up for self-directed care.

G2. Who can get self-directed care

Depending on your LTSS Waiver eligibility, you may be able to select a Personal Assistant (PA)

service. Self-directed care allows you to choose who will provide personal care services to you. If you qualify, your care coordinator can assist you with signing up for self-directed care.

G3. How to get help in employing personal care providers

If you employ a PA, it is your responsibility to ensure the following:

- You need to complete and submit all necessary documentation to the local Division of Rehabilitation Services (DRS) office prior to the start of employment of the PA. This includes information in both the Member and PA packets.
- You need to select a PA that has the physical capability to perform the tasks under your direction, and the PA will not have a medical condition which will be aggravated by the job requirements.
- You need to provide a copy of and review your Service Level Plan with your PA so they understand your needs and hours approved.
- You will review the Time Sheet with your PA for accuracy of all information before you turn it in and only approve hours actually worked by the PA for payment.
- Time Sheets will not be pre-signed or submitted prior to the last day worked in a billing period.
- Complete the PA's Last Day of Employment form (in your Personal Assistant packet) and send to the DRS office when any PA's employment ends.
- Notify the DRS office within 24 hours of any incident resulting in injury to the PA at work.

Complete the Report of Injury to a Provider form (in your packet) and mail or fax it to the DRS office within 24 hours after you reported it.

H. How to get transportation services

You can call Member Services at the phone number located on the back of this booklet if you need assistance scheduling your transportation or have any questions about transportation services.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

I1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury.

The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
    - there is not enough time to safely transfer you to another hospital before delivery.
    - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. You can call Member Services at the phone number located on the back of this booklet.

Covered services in a medical emergency

Our plan does not provide coverage for emergency medical care outside the United States and its territories.

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What to do if you have a behavioral health emergency

If you are having a behavioral health emergency, please contact the CARES (Crisis and

Referral Entry Service) Line at the numbers listed below. You can also find more information in Chapter 2, Section D. The CARES Line is a toll-free advice line available to you 24 hours a day, 7 days a week, 365 days a year. We can assist you in scheduling emergency behavioral health appointments. Please call us if you are having suicidal thoughts or are experiencing symptoms of a mental health illness. If you are having a medical emergency, please call 911.

CALL	1-800-345-9049 This call is free. 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	1-866-794-0374 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, 365 days a year.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care *only* if:

- you use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right

away. For example, you might have a flare-up of an existing condition or. an unforeseen illness or injury.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, given your time, place, or circumstances, we will cover urgently needed care you get from an out-of-network provider.

You can find in-network urgent care facilities in our *Provider and Pharmacy Directory* and online at mmp.ilmeridian.com/member/benefits-coverage/tools-resources/provider-search.html. You can also call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States.

I3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Meridian.

Please visit our website for information on how to obtain needed care during a declared disaster: mmp.ilmeridian.com/resources/disaster-local-emergency-coverage.html.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5, Section A8 for more information.

J. What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7, Section A to learn what to do.

J1. What to do if services are not covered by our plan

Meridian covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4, Section D), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section D explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. Coverage of health care services covered when you are in a clinical research study?

K1. Definition of a clinical research study

A clinical research study (also called a *clinical trial*) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How your health care services are covered when you get care in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Coverage is unlimited for plan approved inpatient hospital care. Please refer to the Benefits Chart on Chapter 4, Section D for more information.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Meridian, you usually will not own the rented equipment, no matter how long you rent it.

In certain situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

Even if you had the durable medical equipment for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

NOTE: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2025* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan **and**
- you leave our plan and get your Medicare benefits through Original Medicare instead of a health plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the 13 payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents

- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Meridian Medicare-Medicaid Plan (MMP) covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you what services Meridian covers. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section A. This chapter also explains limits on some services.

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan's rules. Refer to Chapter 3, Section B for details about the plan's rules.

If you need help understanding what services are covered, call your Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

A1. During public health emergencies

Meridian will follow any and all state and/or federal guidance related to a Public Health Emergency (PHE). During a PHE, the plan will provide all necessary coverage for our members. The coverage may vary depending on the services received and the duration of the PHE. Please visit our website for more information on how to obtain needed care during a PHE at mmp.ilmeridian.com/resources/disaster-local-emergency-coverage.html or call Member Services. You can reach Member Services at the phone number printed on the bottom of this page.

B. Rules against providers charging you for services

We do not allow Meridian Medicare-Medicaid Plan (MMP) providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7, Section A or call Member Services.

C. Our plan's Benefits Chart

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections, General Services offered to all enrollees, and Home and Community-based Services offered to enrollees who qualify through a home and community-based services waiver program.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the

coverage requirements described below.

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules. Medically necessary refers to all covered services that are within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of disease, illness, or injury.
- For new enrollees, the plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3, Section D has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization* (PA). Covered services that need PA are marked in the Benefits Chart in bold type. In addition, you must get PA for the following services that are not listed in the Benefits Chart:
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
    - Any scheduled inpatient stay (e.g. elective surgeries)

- Any service performed by an out of network provider
- Transaortic Valve Replacement (TAVR)
- Automatic Implantable Cardioverter Defibrillators (AICD)
- Pain Management Procedures
- Hyperbaric Therapy
- Infertility Testing and Treatment
- Varicose Vein: Surgical Treatment and Sclerotherapy
- Ventricular Assist Devices
- Routine Maternity Care
- Cardiac Implants
- Sleep Studies
- Transthoracic Echocardiogram (TTE)
- Coronary Angioplasty/Stent Procedures
- Bone Growth Stimulators
- 3 D Mammography
- Transcranial Ultrasound
- Carotid Endarterectomy (CEA) and Carotid Artery Stenting (CAS) and Carotid/ Aorta Doppler
- Pulmonary Stress Testing
- Doppler Ultrasound of Extremity
- Pulse Volume Recording
- Cardiac Ablation
- Cardioversion (internal/external)
- Spinal Fusion

- All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.

D. The Benefits Chart

Services that our plan pays for		What you must pay
	Abdominal aortic aneurysm screening The plan will cover a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse.	$0
	Alcohol misuse screening and counseling The plan covers one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, the plan covers up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0

Services that our plan pays for		What you must pay
	Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 **Prior Authorization rules may apply**
	Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will cover this once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.	$0
	Bone mass measurement The plan covers certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will cover the services once every 24 months, or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0

Services that our plan pays for		What you must pay
	Breast cancer screening (mammograms) The plan will cover the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and older • clinical breast exams once every 24 months	$0
	Cardiac (heart) rehabilitation services The plan covers cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 **Prior Authorization rules may apply**
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: • discuss aspirin use, • check your blood pressure, **or** • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. Additional testing may be covered if deemed medically necessary by your primary care provider.	$0
	Cervical and vaginal cancer screening The plan covers the following services: • For all women: Pap tests and pelvic exams once every 12 months	$0

Services that our plan pays for		What you must pay
	Chiropractic services The plan covers adjustments of the spine to correct alignment.	$0
	Colorectal cancer screening The plan will pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Colorectal cancer screening (continued) • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.	

Services that our plan pays for		What you must pay
	**Counseling to stop smoking or tobacco use** If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will cover two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. • If you use tobacco and are pregnant: • The plan will cover three counseling quit attempts within a 12 month period. This service is free for you. Each counseling attempt includes up to four face-to-face visits.	$0 **Prior Authorization rules may apply**
	Dental services The plan covers the following dental services: • limited and comprehensive exams • restorations • dentures • extractions • sedation • dental emergencies • dental services necessary for the health of a pregnant woman prior to delivery of her baby **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Dental services (continued) We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. Meridian covers dental services in accordance with the state Medicaid program. Actual number and frequency of services may vary based on medical necessity.	$0
	Depression screening The plan will cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.	$0
	Diabetes screening The plan will cover this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0

Services that our plan pays for		What you must pay
	Diabetic self-management training, services, and supplies The plan will cover the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan will cover the following: ○ one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also cover fitting the therapeutic custom-molded shoes or depth shoes. • The plan will cover training to help you manage your diabetes, in some cases. OneTouch™ products by Lifescan are our preferred diabetic testing supplies (glucose monitors & test strips). Other brands are not covered unless medically necessary and pre-authorized.	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay

	Emergency care
	
	Emergency care means services that are:
	• given by a provider trained to give emergency services, **and**
	• needed to treat a medical emergency.
	
	A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• serious risk to your health or to that of your unborn child; **or**
	• serious harm to bodily functions; **or**
	• serious dysfunction of any bodily organ or part; **or**
	• in the case of a pregnant woman in active labor, when:
	  ○ there is not enough time to safely transfer you to another hospital before delivery.
	  ○ a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	Emergency care is only covered within the United States and its territories.
		$0
		
		If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay. Once your condition is stable, you will be required to use in-network providers for any follow up care.

Services that our plan pays for		What you must pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will cover the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (birth control pills, patch, ring, IUD, injections, implants) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility, and related services • counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • treatment for sexually transmitted infections (STIs) • voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • genetic counseling • folic acid supplements and prenatal vitamins ordered by prescription and dispensed by a pharmacy The plan will also cover some other family planning services. However, you must use a provider in the plan's network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • fertility preservation services • treatment for AIDS and other HIV-related conditions • genetic testing	$0

Services that our plan pays for		What you must pay
	Gender-affirming services For members with a diagnosis of gender dysphoria, the plan covers gender-affirming services. Some screenings and services are subject to PA and referral requirements.	$0 **Prior Authorization rules may apply** You should talk to your provider and get a referral.

	Health and wellness education programs **Enhanced Disease Management** • Meridian uses evidence-based practice guidelines (clinical guidelines based on the best research) as a basis for our disease management programs. These programs help you to live as healthy as possible and to feel your best. Authorization and criteria rules apply. **Health Education** • Meridian partners with community resources and health plan providers to encourage health plan members to participate in educational events to enhance self-care skills and emphasize healthy lifestyles. Meridian also provides health plan members with health education resources to enhance self-care skills and promote overall health education. **Remote Access Technologies (including Web/Phone based technologies and Nurse Advice Call Line):** • Meridian offers 24 hours per day, 7 days a week, 365 days a year virtual visit access to board certified doctors to help address a wide variety of health concerns/questions. A virtual visit (also known as a virtual consult) is a visit with a doctor either over the phone, smart phone app, or online. • Meridian's 24-Hour Nurse Advice Call Line is available 24-hours, 7 days a week, 365 days a year. You can call our 24-Hour Nurse Advice Call Line any time of the night or day to receive trusted health information and advice from the comfort of your home. A nurse will call you back with additional advice and information based on your health questions and needs. To contact Meridian's nurse hotline, please call the member services number on the back of this booklet. • Annual membership at a participating fitness center, or for members who do not live near a participating fitness center, and prefer to exercise at home, see another option below. **This benefit is continued on the next page**	$0 **Prior Authorization rules may apply** You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Health and wellness education programs (continued) **Fitness Membership Benefit** Members can choose from available exercise programs to be shipped to them at no cost. A fitness tracker is included in the home kit. For more information regarding the fitness benefit or to find a participating fitness center location, please call Member Services (phone numbers are printed on the back cover of this booklet).	
	Hearing services The plan covers hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan also covers the following: • basic and advanced hearing tests • hearing aid counseling • fitting/evaluation for a hearing aid • hearing aids once every three years • hearing aid batteries and accessories • hearing aid repair and replacement of parts	$0 **Prior Authorization rules may apply**
	HIV screening The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0

Services that our plan pays for		What you must pay
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will cover the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0 **Prior Authorization rules may apply** You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0

Services that our plan pays for		What you must pay
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following while you are getting hospice services: • drugs to treat symptoms and pain • short-term respite care • home care, including home health aide services • occupational, physical and speech-language therapy services to control symptoms • counseling services **Hospice services and services covered by Medicare Part A or B are billed to Medicare:** • Refer to Section F of this chapter for more information. **For services covered by Meridian but not covered by Medicare Part A or B:** • Meridian will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by Meridian's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Hospice care (continued) **Note:** If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can reach your care coordinator at 1-855-580-1689 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.	
	Immunizations The plan will cover the following services: • pneumonia vaccine • flu/influenza shots, once each flu/influenza season, in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • other vaccines if you are at risk and they meet Medicare Part B coverage rules The plan will cover other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D to learn more.	$0

Services that our plan pays for		What you must pay
	Inpatient hospital care The plan will cover the following services, and maybe other services not listed here: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • blood, including storage, blood components and administration thereof • physician services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. **This benefit is continued on the next page**	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Inpatient hospital care (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you must get your transplant services locally. If you can't get your transplant services locally, or your provider has told us why you need services outside the pattern of care for your community, we will arrange or pay for lodging and travel costs for you and one other person. All transplant services require prior plan authorization. Lodging and travel costs require prior plan approval and are subject to plan limitations. The plan will only arrange or pay for lodging and travel for care that is related transplant services. For more information on transplant services, including travel cost limitations, please call Member Services at the numbers listed on the back of this booklet.	
	Inpatient services in a psychiatric hospital The plan will cover medically necessary psychiatric inpatient care at approved institutions.	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay

	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay
	If your inpatient stay is not reasonable and necessary, the plan will not pay for it.
	However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:
	• doctor services
	• diagnostic tests, like lab tests
	• X-ray, radium, and isotope therapy, including technician materials and services
	• surgical dressings
	• splints, casts, and other devices used for fractures and dislocations
	• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:
	  ○ replace all or part of an internal body organ (including contiguous tissue), **or**
	  ○ replace all or part of the function of an inoperative or malfunctioning internal body organ.
	• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition
	• physical therapy, speech therapy, and occupational therapy
		$0
		Prior Authorization rules may apply

Services that our plan pays for		What you must pay

	Kidney disease services and supplies
	
	The plan will cover the following services:
	• kidney disease education services to teach kidney care and help members make good decisions about their care
	  ○ you must have stage IV chronic kidney disease, and your doctor must refer you
	  ○ the plan will cover up to six sessions of kidney disease education services
	• outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B or when your provider for this service is temporarily unavailable or inaccessible
	• inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care
	• self-dialysis training, including training for you and anyone helping you with your home dialysis treatments
	• home dialysis equipment and supplies
	• certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply
	
	Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.
		$0
		
		Prior Authorization rules may apply

Services that our plan pays for		What you must pay
	Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer *or* smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
	Meals **Post-Acute Meals** The Plan offers home-delivered meals immediately following an inpatient hospital stay to aid in a member's recovery. The Total post-acute benefit offers 3 meals per day with a duration of 14-days, having a maximum of 42 meals per occurrence for an unlimited number of occurrences per year. **Chronic Meals** The Plan also offers home-delivered meals as part of a supervised program designed to transition members with chronic conditions to lifestyle modifications. The member must have chronic heart failure, chronic obstructive pulmonary disease (COPD), acquired immunodeficiency syndrome (AIDS), asthma, coronary artery disease (CAD), diabetes, and/or hypertension to qualify for the benefit. The total chronic meals benefit is 3 meals per day for up to 28 days for a maximum of 84 meals per month. The chronic meals benefit can be received for up to 3 months.	$0 You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Medical equipment and related supplies The following general types of services and items are covered: • nondurable medical supplies, such as surgical dressings, bandages, disposable syringes, incontinence supplies, ostomy supplies and enteral nutrition therapy • durable medical equipment (DME), such as wheelchairs, crutches, power mattress systems, diabetic supplies, walkers, hospital beds ordered by a provider for use in the home, Intravenous (IV) infusion pumps, humidifiers, speech generating devices, and walkers (for a definition of "Durable medical equipment," refer to Chapter 12, as well as Chapter 3, Section M, of this handbook) • prosthetic and orthotic devices, compression stockings, shoe orthotics, arch supports, foot inserts • respiratory equipment and supplies, such as oxygen equipment, CPAP and BIPAP equipment • repair of durable medical equipment, prosthetic devices and orthotic devices • rental of medical equipment under circumstances where patient's needs are temporary To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria. We will pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor. The plan will cover three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.	$0
	Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Some drugs may be subject to step therapy, which means you would have to try a different drug first to see if it works for you. Meridian will cover the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • the Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV) • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B does not cover them if you were enrolled in Medicare Part A at the time of the organ transplant • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself **This benefit is continued on the next page**	$0 **Prior Authorization rules may apply**

	Medicare Part B prescription drugs (continued) • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued) The following link will take you to a list of Part B drugs that may be subject to step therapy: https://mmp.ilmeridian.com/pharmacy/formulary.html We also cover some vaccines under our Medicare Part B and most adult vaccines under our Part D prescription drug benefit. Chapter 5**,** Section A explains the outpatient prescription drug benefit**.** It explains rules you must follow to have prescriptions covered. Chapter 6, Section C explains what you pay for your outpatient prescription drugs through our plan.	
	Non-emergency transportation The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of non-emergency transportation include: • Medicare • non-emergency ambulance • service car • taxicab/Bus/subway • Van medical transport	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Nursing facility (NF) care and skilled nursing facility (SNF) care The plan will cover skilled nursing facilities (SNF) and intermediate care facilities (ICF). The plan will pay for the following services and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary, maintenance and cleaning • meals, including special meals, food substitutes, and nutritional supplements • nursing services and resident supervision/oversight • physician services • physical therapy, occupational therapy, and speech therapy • drugs, and other medications available through a pharmacy without a prescription, ordered by your doctor as part of your plan of care, including over-the-counter medications and their administration • non-custom durable medical equipment (such as wheelchairs and walkers) • medical and surgical supply items (such as bandages, oxygen administration supplies, oral care supplies and equipment, one tank of oxygen per resident per month) • additional services provided by a nursing facility in compliance with state and federal requirements **This benefit is continued on the next page**	When your income exceeds an allowable amount, you must contribute toward the cost of services. This is known as the patient pay amount and is required if you live in a nursing facility. However, you may not end up having to pay an amount each month. Patient pay responsibility does not apply to Medicare-covered days in a nursing facility. **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Nursing facility (NF) care and skilled nursing facility (SNF) care (continued) You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital.	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will cover counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • substance use disorder counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0 You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Outpatient diagnostic tests and therapeutic services The plan will cover the following services, and maybe other services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • lab tests • blood, blood components and administration thereof • other outpatient diagnostic tests	$0 **Prior Authorization rules may apply**

	Outpatient hospital services
	
	The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.
	
	The plan will cover the following services, and maybe other services not listed here:
	• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ observation services help your doctor know if you need to be admitted to the hospital as an "inpatient."
	  ○ sometimes you can be in the hospital overnight and still be an "outpatient."
	  ○ you can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101.
	
	This benefit is continued on the next page
		$0
		
		Prior Authorization rules may apply

Services that our plan pays for		What you must pay
	Outpatient hospital services (continued) • labs and diagnostic tests billed by the hospital • mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • medical supplies, such as splints and casts • preventive screenings and preventive services listed throughout the Benefits Chart • some drugs that you can't give yourself	
	Outpatient mental health care The plan will cover mental health services provided by: • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a nurse practitioner (NP), • a physician assistant • a licensed clinical professional counselor (LPC), • a licensed marriage and family therapist (LMFT) • Community Mental Health Centers (CMHCs), • Behavioral Health Clinics (BHCs), • hospitals, • encounter rate clinics such as Federally Qualified Health Centers (FQHCs), **or** • any other Medicare-qualified mental health care professional as allowed under applicable state laws. **This benefit is continued on the next page**	$0 You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Outpatient mental health care (continued) The plan will cover the following types of outpatient mental health services: • clinic services provided under the direction of a physician • rehabilitation services recommended by a physician or Licensed Practitioner of the Healing Arts, such as Integrated Assessment and Treatment Planning, crisis intervention, therapy, and case management • day treatment services • outpatient hospital services, such as Clinic Option Type A and Type B services The specific services each provider type listed above can deliver and any utilization controls on such services shall be determined by the plan consistent with federal and state laws and all applicable policies and/or agreements.	

Services that our plan pays for		What you must pay
	Outpatient mental health crisis services (expanded) In addition to crisis intervention services, the plan will cover the following medically necessary crisis services: • Mobile Crisis Response (MCR): MCR is a mobile, time-limited service for crisis symptom reduction, stabilization, and restoration to the previous level of functioning. MCR services require a face-to-face screening using a state approved crisis-screening instrument and may include: short-term intervention, crisis safety planning, brief counseling, consultation with other qualified providers, and referral to other mental health community services. To access MCR services, health plan members or individuals concerned about health plan members should call the state's crisis intake line, CARES, at 1-800-345-9049 (TTY: 1-866-794-0374). CARES will dispatch a local provider to the location of the health plan member in crisis. • Crisis Stabilization: Crisis stabilization services are time-limited, intensive supports available for up to 30 days following an MCR event to prevent additional behavioral health crises. Crisis stabilization services provide strengths-based support on a one-on-one basis in the home or community. The health plan will cover Mobile Crisis Response and Crisis Stabilization services provided by: • Community Mental Health Centers with a crisis certification from the state, **or** • Behavioral Health Clinics with a crisis certification from the state.	$0
	Outpatient rehabilitation services The plan will cover physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0 **Prior Authorization rules may apply** You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Outpatient surgery The plan will cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0 **Prior Authorization rules may apply**
	Over-the-counter drugs (OTC) The plan covers limited OTC items available by mail and select CVS pharmacy retail stores at no cost to you. Contact Meridian for more information. Members may use their OTC benefit to purchase eligible OTC items from participating locations or from the OTC catalog for delivery to their door. The items covered by the benefit are limited to items that are consistent with CMS guidance in the most recent version of Chapter 4 of the Medicare Managed Care Manual. The value of the purchased item(s) is based on the retail price charged by the merchant, including sales tax and shipping for mail order, as applicable, and cannot be converted to cash. Your card can be used at participating retail locations, via mobile app, or login to your member portal to place an order for home delivery. Covered items include: • Brand name and generic over-the-counter items • Vitamins, pain relievers, cold and allergy items, diabetes items • Use your in-app barcode scanner to locate approved items at retail locations, or log into your member portal or refer to your catalog. **Note:** Under certain circumstances diagnostic equipment and smoking-cessation aids are covered under the plan's medical benefits. You should (when possible) use our plan's medical benefits prior to spending your OTC allowance for these items.	$0 As an extra benefit, our plan covers up to $50 per calendar month for eligible over-the-counter (OTC) items. This OTC benefit is limited to one order per calendar month. Any unused amounts do not carry over to the next calendar month. Certain items may have a quantity limit, and are noted in your catalog. Multiples of single items may be limited, per order. There is no limit on the number of total items in your order. This benefit can only be used to order OTC products for the member. Please contact the plan for more information.

Services that our plan pays for		What you must pay
	Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits The plan will cover the following services: ● medically necessary health care or surgery services given in places such as: ○ physician's office ○ certified ambulatory surgical center ○ hospital outpatient department ● consultation, diagnosis, and treatment by a specialist ● basic hearing and balance exams given by your specialist, if your doctor orders them to find out whether you need treatment ● Certain telehealth services, including: Urgent Needed Services, Home Health Services, Primary Care Physician, Specialist, Individual Sessions for Mental Health, Podiatry Services, Other Health Care Professional, Individual Sessions for Psychiatric, Individual Sessions for Outpatient Substance Abuse, and Diabetes Self-Management Training ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. **This benefit is continued on the next page**	$0 You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits (continued) • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o you have an in-person visit within 6 months prior to your first telehealth visit o you have an in-person visit every 12 months while receiving these telehealth services o exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o you're not a new patient **and** o the check-in isn't related to an office visit in the past 7 days **and** o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay

	Physician/provider services, including doctor's office visits (continued)
	• evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:
	  ○ you're not a new patient **and**
	  ○ the evaluation isn't related to an office visit in the past 7 days **and**
	  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
	• consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
	• second opinion by another network provider before surgery
	• Non-routine dental care. Covered services are limited to:
	  ○ surgery of the jaw or related structures,
	  ○ setting fractures of the jaw or facial bones,
	  ○ pulling teeth before radiation treatments of neoplastic cancer, **or**
	  ○ services that would be covered when provided by a physician.	

	Podiatry services The plan will cover the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes	$0

Services that our plan pays for		What you must pay
	Prostate cancer screening exams The plan will cover a digital rectal exam and a prostate specific antigen (PSA) test once every 12 months for: • men age 50 and older • African American men age 40 and older • men age 40 and older with a family history of prostate cancer	$0
	Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but are not limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) The plan will also cover some supplies related to prosthetic and orthotic devices. They will also pay to repair or replace prosthetic and orthotic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section for details.	$0 **Prior Authorization rules may apply**
	Pulmonary rehabilitation services The plan will cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Sexually transmitted infections (STIs) screening and counseling The plan will cover screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. The plan will also cover up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will cover these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
	Substance use disorder services The plan will cover substance use disorder services provided by: • a state-licensed substance use disorder facility **or** • hospitals. The plan will cover the following types of medically necessary substance abuse services: • outpatient services (group or individual), such as assessment, therapy, medication monitoring, and psychiatric evaluation, • Medication Assisted Treatment (MAT) for opioid dependency, such as ordering and administering methadone, managing the care plan, and coordinating other substance use disorder services, • intensive outpatient services (group or individual), • detoxification services, **and** • some residential services, such as short-term Rehabilitation Services.	$0 You should talk to your provider and get a referral.

Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0 **Prior Authorization rules may apply**

Services that our plan pays for		What you must pay
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency, **or** • an unforeseen medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your time, place, or circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Urgently needed care is only covered within the United States and its territories.	$0

Services that our plan pays for		What you must pay

	**Vision care**
	The plan covers the following:
	• annual routine eye exams
	  ○ eye glasses (lenses and frames)
	  ○ frames limited to one pair in a 24 month period
	• lenses limited to one pair in a 24 month period, but you may get more when medically necessary, with prior approval
	• custom-made artificial eye
	• low vision devices
	• contacts and special lenses when medically necessary, with prior approval
	To be eligible for reimbursement, some services may be subject to prior approval and/or medical criteria.
	The plan covers outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.
	This benefit is continued on the next page
		$0

Services that our plan pays for		What you must pay
	Vision care (continued) For people at high risk of glaucoma, the plan covers one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, **and** • Hispanic Americans who are 65 or older. The plan covers one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery).	
	"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

Home and community-based services that our plan covers		What you must pay
	Adult day service The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: • provides personal attention • promotes social, physical and emotional well-being	$0
	Assisted living If you qualify, the Supportive Living Facility provides an alternative to Nursing Facility placement. Some of the services include the following: • assistance with activities of daily living • nursing services • personal care • medication administration • housekeeping • 24 hour response/security staff	$0
	Habilitation – day The plan covers day habilitation, which assists with the retention or improvement in self help, socialization and adaptive skills outside the home if you qualify.	$0
	Home delivered meals The plan covers prepared meals brought to your home if you qualify.	$0

Home and community-based services that our plan covers		What you must pay
	Home health aide The plan covers services from a home health aide, under the supervision of a registered nurse (RN) or other professional, if you qualify. Services may include the following: • simple dressing changes • assistance with medications • activities to support skilled therapies • routine care of prosthetic and orthotic devices	$0
	Home modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • ramps • grab-bars • doorway widening	$0
	Homemaker services The plan covers home care services provided in your home or community if you qualify. These services may include the following: • a worker to help you with laundry • a worker to help you with cleaning • training to improve your community living skills	$0
	Nursing services The plan covers shift and intermittent nursing services by a registered nurse (RN) or licensed practical nurse (LPN) if you qualify.	$0

Home and community-based services that our plan covers		What you must pay
	Personal assistant The plan covers a personal assistant to help you with activities of daily living if you qualify. These include, for example: • bathing • feeding • dressing • laundry	$0
	Personal emergency response system The plan covers an electronic in home device that secures help in an emergency if you qualify.	$0
	Respite care The plan covers respite services to provide relief for an unpaid family member or primary caregiver who meet all of your service needs if you qualify. Certain limitations apply.	$0
	Specialized durable medical equipment and supplies If you qualify, the plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include: • Hoyer lift • shower benches/chairs • stair lift • bed rails	$0
	Therapies The plan covers occupational, physical, and speech therapy if you qualify. These therapies focus on long term habilitative needs rather than short term acute restorative needs.	$0

E. Benefits covered outside of Meridian

The following services are not covered by Meridian but are available through Medicare or Medicaid.

Abortion services are covered by Medicaid (not our plan) by using your Healthcare and Family Services (HFS) medical card.

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Meridian pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Meridian's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3.

Note: If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can reach your care coordinator at 1-855-580-1689, Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

F. Benefits not covered by Meridian, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9, Section D.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3, Section K for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Radial keratotomy and LASIK surgery.
- Reversal of sterilization procedures.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. Members are still responsible for their cost sharing amounts.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Meridian Medicare-Medicaid Plan (MMP) also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in Chapter 4, Section D.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription. Or you can fill your prescription through the plan's mail-order service.
4. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to section B of this chapter.)
    - If it is not on the *Drug List*, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9, Section F2, to learn about asking for an exception.
5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain

medical references. For Medicaid covered drugs, this means the use of the drug is within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of a disease, illness, or injury.

6. Your drug may require approval before we will cover it. Refer to Section C.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions **only** if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Meridian Member ID Card** at your network pharmacy. The network pharmacy will bill Meridian Medicare-Medicaid Plan (MMP) for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7, Section A.
- If you need help getting a prescription filled, you can contact Member Services or your care coordinator.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, you can contact Member Services or your care coordinator.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy. We will send you a letter to notify you if a pharmacy you use leaves the network and we will assist you in finding a new network pharmacy. To find another network pharmacy in your area, you can get help from Member Services (phone number is printed on the bottom of this page) or use the *Provider*

and Pharmacy Directory. You can also find information on our website at mmp.ilmeridian.com/member/benefits-coverage/tools-resources/provider-search.html.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator (phone number is printed on the bottom of this page).

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care coordinator.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs that are not available through the plan's mail-order service are marked with "NM" in our *Drug List*.

Our plan's mail-order service allows you to order up to a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get mail-order forms and information about filling your prescriptions by mail, call 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Usually, a mail-order prescription will get to you within 10-14 days. If your order is delayed, contact Express Scripts® Pharmacy 1-833-750-0201 (TTY: 711). Or, log on to express-scripts.com/rx.

Mail-order processes

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy gets from you**

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets directly from your provider's office**

   The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

   - You used mail-order services with this plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711).

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711).

   If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped.
   - It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, please contact us by calling Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711).

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Express Scripts® Pharmacy at 1-833-750-0201 (TTY: 711).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You should verify your contact information each time you place an order, at the time you enroll in the automatic refill program or if your contact information changes.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above A6 to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- You travel outside the plan's service area and need a drug that you can't get at a network pharmacy close to you.
- You need a drug urgently and there is no network pharmacy that is close to you and open.
- You must leave your home due to a federal disaster or other public health emergency.

Generally, we will cover a one-time fill, up to a 30-day supply at an out-of-network pharmacy in these situations.

A9. Paying you back if you pay for a prescription

If you must use an out-of-network pharmacy, you will generally have to pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to Chapter 7, Section A.

B. The plan's *Drug List*

The plan has a *List of Covered Drugs*. We call it the "*Drug List*" for short.

The drugs on the *Drug List* are selected by the plan with the help of a team of doctors and pharmacists. The *Drug List* also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's *Drug List* as long as you follow the rules explained in this chapter.

B1. Drugs on the *Drug List*

The *Drug List* includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and items covered under your Medicaid benefits.

The *Drug List* includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the *Drug List*, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs *or* biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to Chapter 12 for definitions of the types of drugs that may be on the *Drug List.*

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on the *Drug List*

To find out if a drug you are taking is on the *Drug List*, you can:

- Check the most recent *Drug List* we sent you in the mail.
- Visit the plan's website at mmp.ilmeridian.com/pharmacy/formulary.html. The *Drug List* on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's *Drug List* or to ask for a copy of the list.

Use our "Real Time Benefit Tool" at mmp.ILmeridian.com or call your care coordinator or Member Services. With this tool you can search for drugs on the *Drug List* to get an estimate of what you will pay and if there are alternative drugs on the *Drug List* that could treat the same condition

B3. Drugs that are not on the *Drug List*

The plan does not cover all prescription drugs. Some drugs are not on the *Drug List* because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the *Drug List*.

Meridian Medicare-Medicaid Plan (MMP) will not pay for the drugs listed in this section These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9, Section F5.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered under our plan's medical benefit by

Meridian for free, but they are not considered part of your outpatient prescription drug benefits.

2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor or other provider might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- drugs used to promote fertility
- drugs used for cosmetic purposes or to promote hair growth
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- drugs used for treatment of anorexia, weight loss, or weight gain
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. *Drug List* tiers

Every drug on the plan's *Drug List* is in one of three tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 (Generic Drugs) includes generic drugs.
- Tier 2 (Brand Drugs) includes brand drugs and may include some generic drugs.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescriptions and over-the-counter (OTC) generic and brand drugs that are covered by Medicaid.

To find out which tier your drug is in, look for the drug in the plan's *Drug List*.

Chapter 6, Section C4, tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective.

When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9, Section F2.

1. **Limiting use of a brand name drug or original biological products when, respectively, a generic or interchangeable biosimilar version is available.**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies will give you, respectively, the generic or interchangeable biosimilar version.

   - We usually will not pay for the brand name drug or original biological product when there is a generic version.
   - However, if your provider has told us the medical reason that neither the generic drug interchangeable biosimilar nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from Meridian, based on specific rules, before you fill your prescription. If you don't get approval, Meridian may not cover the drug.

3. **Trying a different drug first**

   In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

   If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. **Quantity limits**

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the *Drug List*. For the most up-to-date information, call Member Services or check our website at mmp.ilmeridian.com/pharmacy/formulary.html.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan**.** The drug might not be on the *Drug List*. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above, Section C some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the *Drug List* or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan's *Drug List*, **or**
   - was never on the plan's *Drug List*, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.

- We will cover a temporary supply of your drug **during the first 90 days of the calendar year**.
- This temporary supply will be for up to a 30-day supply at a retail pharmacy and a 31-day supply at a long-term care pharmacy.
- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
  - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
  - This temporary supply will be for up to a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy.
  - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - If your level of care changes (such as moving to or from a long-term care facility or hospital), we will cover one temporary 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.

- Such level of care transitions may include, but are not limited to:
  - Members who are discharged from a hospital or skilled-nursing facility to a home setting

  - Members who are admitted to a skilled-nursing facility from a home setting
  - Members who transfer from one skilled-nursing facility to another and are served by a different pharmacy
  - Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
  - Members who give up hospice status

- Members discharged from chronic psychiatric hospitals with highly individualized care.

If you change treatment settings multiple times within the same month, your pharmacy may need to contact the plan for continued coverage. If you do not request continued coverage from the plan, you do not qualify for an additional level of care temporary supply unless it's a life-threatening emergency.

  - To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- You can ask for an exception.

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the *Drug List*. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

If a drug you are taking will be taken off the *Drug List* or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.

- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9, Section F4.

If you need help asking for an exception, you can contact Member Services or your care coordinator.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Meridian may add or remove drugs on the *Drug List* during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from Meridian before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless**:**

- a new, cheaper drug comes on the market that works as well as a drug on the *Drug List* now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you are taking?

To get more information on what happens when the *Drug List* changes, you can always:

- Check Meridian's up to date *Drug List* online at mmp.ilmeridian.com/pharmacy/formulary.html **or**
- Call Member Services to check the current *Drug List* at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the

brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook, Section F4 for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or effective or the drug's manufacturer takes a drug off the market, we may immediately take it off the *Drug List*. If you are taking the drug, we will send you a notice after we make the change. Please talk to your doctor or other prescriber to help you decide if there is a similar drug on the *Drug List* that you can take instead.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the *Drug List*. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the *Drug List* **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the *Drug List* you can take instead **or**
- Whether to ask for an exception from these changes to continue covering the drug or the version of the drug you have been taking. To learn more about asking for exceptions, refer to Chapter 9, Section F2.

Changes to the Drug List that do not affect you during the current plan year

We may make changes to the drugs you take that are not described above and do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you are taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We will not tell you above these types of changes directly during the current year. You will need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify

that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4, Section E1.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you are taking another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal

medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services or your care coordinator.

G3. Drug management program to help members safely use their opioid medications

Meridian has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacies** and/or **from certain prescribers**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to

limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to **Chapter 9**, Section F5.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- The plan’s *List of Covered Drugs*.
  - We call this the “*Drug List*.” It tells you:
    - Which drugs the plan pays for
    - Which of the three tiers each drug is in
    - Whether there are any limits on the drugs
  - If you need a copy of the *Drug List*, call Member Services. You can also find the *Drug List* on our website at mmp.ilmeridian.com/pharmacy/formulary.html. The *Drug List* on the website is always the most current.
- Chapter 5 of this *Member Handbook*.

- Chapter 5, Section A tells how to get your outpatient prescription drugs through the plan.
- It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.

- The plan's *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call or Member Services for more information.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drug costs. This is the amount of money the plan pays (or others pay on your behalf) for your prescriptions. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you or others on your behalf pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information**. This is your total drug costs and the total payments made since January 1.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you have paid for. You can ask us to pay you back for the drug.

   Here are some times when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program
   - When you buy covered drugs at an out-of-network pharmacy
   - When you pay the full price for a covered drug

   To learn how to ask us to pay you back for the drug, refer to Chapter 7, Section A.

3. **Send us information about the payments others have made for you.**

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. **Check the EOBs we send you.**

   When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing or if you have any questions, please call Member Services. Instead of receiving a paper EOB in the mail, you now have the option of receiving an electronic EOB (eEOB). You may request the eEOB by visiting www.express-scripts.com. If you choose to opt-in, you will receive an email when your eEOB is ready to view, print or download. The eEOBs are also known as paperless EOBs. These eEOBs are exact copies (images) of printed EOBs. Be sure to keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With Meridian, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's tiers

Tiers are groups of drugs on our *Drug List*. Every drug in the plan's *Drug List* is in one of three tiers. You have no copays for prescription and OTC drugs on Meridian's *Drug List*. To find the tiers for your drugs, you can look in the *Drug List*.

- Tier 1 (Generic Drugs) includes generic drugs. The copay is $0.
- Tier 2 (Brand Drugs) includes brand name drugs and may include some generic drugs. The copay is $0.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescriptions and over-the-counter (OTC) generic and brand drugs that are covered by Medicaid. The copay is $0.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5, Section A8 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5, Section A in this handbook and the plan's *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5, Section A7 or the *Provider and Pharmacy Directory*.

C4. What you pay

Your share of the cost when you get a one-month or long-term supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 100-day supply	**The plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A.
Cost Sharing Tier 1 (Generic Drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Cost Sharing Tier 2 (Brand Drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Cost Sharing Tier 3 (Non-Medicare Rx/OTC Drugs)	$0 copay	$0 copay	$0 copay	$0 copay

For information about which pharmacies can give you long-term supplies, refer to the plan's *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs* (*Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

D1. What you need to know before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Meridian to ensure that you do not have any upfront costs for a Part D vaccine.

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, refer to section B.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

Contact Member Services or your care coordinator if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   You should ask the provider to bill the plan.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you have already paid for the service, we will pay you back.

2. **When a network provider sends you a bill**

   Network providers must always bill the plan. Show your Meridian Medicare-Medicaid Plan (MMP) Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because Meridian MMP pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please refer to Chapter 5, Section A8 to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Meridian Medicare-Medicaid Plan (MMP) Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (*Drug List*), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.

  - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9, Section F4).
  - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9, Section F4).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, refer to Chapter 9, Section F5.

B. Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (mmp.ilmeridian.com/provider/provider-tools-resources/documents-and-forms.html), or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to us at this address:

Medical Bills:

Meridian Medicare-Medicaid Plan (MMP)
Attention: Claims
PO Box 4020
Farmington, MO 63640-4402

For medical services, items and non-part D drugs, you must submit your claim to us within one (1) year of the date you got the service, item or drug.

Pharmacy Bills:

Meridian Medicare-Medicaid Plan (MMP)

Medicare Part D Claims

Attn: Member Reimbursement Department
PO Box 31577

Tampa, FL 33631-3577

For part D drugs obtained from a pharmacy, you must submit your claim to us within three (3) years of the date you got the drug.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3, Section B explains the rules for getting your services covered. Chapter 5, Section A explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9, Section D.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9, Section D.

- If you want to make an appeal about getting paid back for a health care service, refer to section Chapter 9, Section E5.
- If you want to make an appeal about getting paid back for a drug, refer to section Chapter 9.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages. The call is free.
- Our plan can also give you materials in languages other than English including Spanish and in formats such as large print, braille, or audio.
    - Meridian Medicare-Medicaid Plan (MMP) wants to make sure you understand your health plan information. We can send materials to you in languages other than English or in alternate formats if you ask for it this way. This is called a "standing request." We will document your choice. Please call us if:
    - You want to get your materials in a language other than English or in an alternate format; or
    - You want to change the language or format that we send you materials.
    - If you need help understanding your plan materials, please contact Meridian Medicare-Medicaid Plan (MMP) Member Services at 1-855-580-1689 (TTY: 711). Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
    - To make a standing request, change a standing request or make a one-time request for materials in a language other than English or in an alternate format, please call Meridian at 1-855-580-1689 (TTY users should call 711). We will document your choice. Hours are from Monday-Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also file a complaint with Medicaid by calling the Illinois Health Benefits Hotline at 1-800-226-0768. TTY users should call 1-877-204-1012.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Su derecho a obtener información de manera tal que satisfaga sus necesidades

Debemos asegurarnos de que **todos** los servicios se le brindan de manera competente y accesible desde el punto de vista cultural. También debemos informarle sobre los beneficios del plan y sus derechos de forma que pueda entenderlos. Debemos comunicarle sus derechos cada año que sea miembro de nuestro plan.

- Para obtener información de forma que pueda entenderla, llame a Servicios al Miembro. Nuestro plan dispone de servicios de interpretación gratuitos para responder preguntas en distintos idiomas. La llamada es gratuita.
- Desde nuestro plan, también podemos proporcionarle materiales en otros idiomas aparte del inglés, como español, y en formatos como letra grande, braille o audio.
    - Meridian Medicare-Medicaid Plan (MMP) quiere asegurarse de que entiende la información de su plan de salud. Si lo solicita, podemos enviarle materiales en idiomas distintos del inglés o en formatos alternativos. A esto se le denomina “solicitud permanente”. Guardaremos su decisión en nuestros registros. Llámenos si desea pedir una de las siguientes opciones:
    - Quiere recibir los materiales en un idioma distinto del inglés o en un formato alternativo; o
    - Quiere cambiar el idioma o el formato en que le enviamos los materiales.
    - Si necesita ayuda para comprender los materiales de su plan, comuníquese con Servicios al Miembro de Meridian Medicare-Medicaid Plan (MMP) al 1-855-580-1689 (TTY: 711). Nuestro horario de atención es de lunes a viernes, de 8 a. m. a 8 p. m. Fuera del horario de atención, los fines de semana y los días feriados, es posible que le pidan que deje un mensaje. Le devolverán la llamada el siguiente día hábil.
    - Para hacer una solicitud permanente, modificar una solicitud permanente o hacer una solicitud única de materiales en un idioma distinto del inglés o en un

formato alternativo, llame a Meridian al 1-855-580-1689 (Los usuarios de TTY deben llamar al 711). Guardaremos su decisión en nuestros registros. Nuestro horario de atención es de lunes a viernes, de 8 a. m. a 8 p. m. Los fines de semana y los feriados estatales o nacionales, es posible que le pidan que deje un mensaje. Le devolverán la llamada el siguiente día hábil. La llamada es gratuita.

Si tiene dificultades para obtener información de nuestro plan debido a problemas de idioma o a una discapacidad y quiere presentar un reclamo, llame a los siguientes departamentos:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- También puede presentar una queja a Medicaid llamando a la línea directa de beneficios de salud de Illinois al 1-800-226-0768. Los usuarios de TTY deben llamar al 1-877-204-1012.
- Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

B. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3, Section D.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a women's health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP. You also have the right to see a dermatologist, audiologist (for routine hearing exams) and an optometrist (for routine vision exams) without a referral.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D4.

Chapter 9, Section C, tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section D, also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights related to your information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the “Notice of Privacy Practice.” The notice also explains how we protect the privacy of your PHI.

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

C2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

MERIDIAN MEDICARE-MEDICAID PLAN (MMP)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

***PLEASE REVIEW IT CAREFULLY*.**

Effective 5/5/2023

For help to translate or understand this, please call 1-855-580-1689 (TTY 711)
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.

1-855-580-1689 (TTY 711).

Covered Entity's Duties:

Meridian is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Meridian is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Meridian reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the

future. Meridian will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Meridian protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.
- ***HealthCare Operations*** - We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

- Quality assessment and improvement activities
- Reviewing the competence or qualifications of healthcare professionals
- Case management and care coordination
- Detecting or preventing healthcare fraud and abuse

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime
- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** – We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.
- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- ***Sale of PHI*** – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing*** – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- ***Psychotherapy Notes*** – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications -*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- ***Right to Access and Receive a Copy of your PHI -*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI -*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures -*** You have the right to receive a list of instances within the last 6-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint -*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling **1-800-368-1019**, (TTY: **1-800-537-7697** or visit the Secretary of the U.S. Department of Health and Human Services website.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- ***Right to Receive a Copy of this Notice -*** You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;

- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone by using the contact information listed below.

Meridian Medicare-Medicaid Plan
Attn: Privacy Official
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

1-855-580-1689 (TTY 711)

D. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Meridian, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. This is a free service. We can also give you information in large print, braille, or audio. To get information about written materials in a language other than English please contact Member Services. To make a standing request, change a standing request or make a one-time request for materials in a language other than English or in an alternate format, please call Meridian at 1-855-580-1689 (TTY users should call 711). We will document your choice. Hours are from Monday-Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how the plan has been rated by plan members
  - the number of appeals made by members
  - how to leave the plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - a list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free. Or visit our website at mmp.ILmeridian.com.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - services and drugs covered by the plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7, Section A.

F. Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible.
- You have the right to get your Medicare benefits through:
    - a different Medicare-Medicaid plan
    - original Medicare
    - a Medicare Advantage plan
- You can get your Medicare Part D prescription drug benefits from:
    - a different Medicare-Medicaid plan
    - a prescription drug plan
    - a Medicare Advantage plan
- Refer to Chapter 10, Section C, for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You can get your Medicaid benefits through:
    - a different Medicare-Medicaid plan
    - Medicaid fee-for-service or a Medicaid Managed Long-Term Services and Supports (MLTSS) health plan

NOTE: If you are getting long-term care or home and community-based waiver services, you must either stay with our plan or choose another plan to get your long-term supports and services.

- To choose a HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) health plan, you can call Illinois Client Enrollment Services at 1-877-912-

8880 from 8 a.m. to 6 p.m. Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Meridian and join a HealthChoice Illinois MLTSS health plan. If you don't pick a health plan, you will be assigned to our company's HealthChoice Illinois MLTSS health plan. Refer to Chapter 10 for more information.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section F4, tells how to ask the plan for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care. To learn more about advance directives in Illinois, use the Illinois Department of Public Health's website at: www.idph.state.il.us/public/books/advin.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid, such as the Illinois Department of Public Health (IDPH), the Illinois Department of Aging (IDoA) and Area Agency on Aging may also have advance directive forms. You can also contact Member Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- **Meridian will make your completed form part of your medical record.** Meridian cannot, as a condition of treatment, require you to fill out or waive an advance directive.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

G3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint by calling the Senior Helpline at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call is free.

H. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section C, tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly - and it is **not** about discrimination for the reasons listed in **Chapter 11** of this handbook - or you would like more information about your rights, you can get help by calling:

- Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.
- The Senior Health Insurance Program at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY users should call 1-888-206-1327. The call is free. For details about this organization, refer to Chapter 2, Section E.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The Senior Helpline at 1-800-252-8966 from 8:30 a.m. to 5 p.m. Monday through Friday. TTY 1-888-206-1327. The call is free.

I. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapter 3, Section A, and Chapter 4, Section A. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapter 5, Section A, and Chapter 6, Section A.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Meridian Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Meridian members, Medicaid pays for your Part A premium and for your Part B premium.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9, Section D, to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Meridian. Chapter 1, Section D, tells about our service area.
  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.
  - Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2, Section G, and Section H, for phone numbers for Medicare and Medicaid.
  - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- Call Member Services for help if you have questions or concerns, at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call the Senior HelpLine at 1-800-252-8966, TTY: 1-888-206-1327.** This chapter explains the options you have for different problems and complaints, but you can always call the Senior HelpLine to help guide you through your problem. The Senior Helpline will help anyone at any age enrolled in this plan. For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section K for more information on ombudsman programs.

Table of Contents

A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Senior HelpLine

If you need help, you can always call the Senior HelpLine. The Senior HelpLine has an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Senior HelpLine is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Senior HelpLine is 1-800-252-8966, TTY: 1-888-206-1327. You can call the Senior Help Line Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free and are available to you no matter how old you are. Refer to Chapter 2, Section K for more information on ombudsman programs.

You can get help from the Senior Health Insurance Program (SHIP)

You can also call the Senior Health Insurance Program (SHIP). SHIP counselors can answer your questions and help you understand what to do to handle your problem. SHIP counselors can help you no matter how old you are. The SHIP is not connected with us or with any insurance company or health plan. The SHIP phone number is 1-800-252-8966, TTY: 1-888-206-1327 and their website is https://www.shiphelp.org/. The call and help are free.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

Getting help from Medicaid

You can call the State of Illinois directly for help with problems. Call the Illinois Department of Healthcare and Family Services Health Benefits Hotline at 1-800-226-0768, TTY: 877-204-1012, Monday through Friday from 8:00 a.m. to 4:30 p.m. The call is free.

Getting help from the Quality Improvement Organization (QIO)

You can call Livanta BFCC-QIO for help with problems. Call Livanta BFCC-QIO at 1-888-524-9900, TTY: 1-888-985-8775, Monday through Friday, 9 a.m. to 5 p.m., local time. For more information, refer to Chapter 2, Section F.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.)	
Yes. My problem is about benefits or coverage. Refer to Section D: **"Coverage decisions and appeals"**.	**No.** My problem is not about benefits or coverage. Skip ahead to Section J: **"How to make a complaint"**.

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Member Services** at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- Call the **Illinois Department of Healthcare and Family Services Health Benefits Hotline** for free help Monday through Friday from 8:00 a.m. to 4:30 p.m. The Illinois Health Benefits Hotline helps people enrolled in Medicaid with problems. The phone number is 1-800-226-0768, TTY: 1-877-204-1012.
- Call the **Senior HelpLine** for free help Monday through Friday from 8:30 a.m. to 5:00 p.m. The Senior Helpline will help anyone at any age enrolled in this plan. The Senior HelpLine is an independent organization. It is not connected with this plan. The phone number is 1-800-252-8966, TTY: 1-888-206-1327.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
    - If you want your doctor or other provider to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://mmp.ilmeridian.com/member/benefits-coverage/tools-resources/documents-and-forms.html. The form gives the person permission to act for you. You must give us a copy of the signed form.
    - Note that under the Medicare program, your doctor or other provider can file an appeal without the “Appointment of Representative” form.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form.
    - You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://mmp.ilmeridian.com/member/benefits-coverage/tools-resources/documents-and-forms.html. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want

a lawyer to represent you, you will need to fill out the Appointment of Representative form.

- However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- Section E gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
  - You are not getting medical care you want, and you believe our plan covers this care.
  - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the *Drug List*, with a "NT" are **not** covered by Part D. Refer to Section F for Part D drug appeals.
  - You got medical care or services you think should be covered, but we are not paying for this care.
  - You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
  - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
    - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H.
  - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will

send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- Section F gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our *Drug List*.
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- Section G gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- Section H gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you need other help or information, please call the Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the *Drug List* with a "NT" are **not** covered by Part D. Use Section F for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

   What you can do: You can ask us to pay you back. Refer to Section E5 on for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Section G and Section H to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-855-580-1689, TTY: 711
- You can fax us at: 1-844-409-5557
- You can write to us at:

Meridian Medicare-Medicaid Plan (MMP)
1333 Burr Ridge Parkway, Suite 100
Burr Ridge, IL 60527

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Or fax us at 1-844-409-5557. For details on how to contact us, refer to Chapter 2, Section A.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical items and/or services you have not yet received.** (You cannot ask for a fast coverage decision if your request is about payment for or services you already got.)

2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.**

    - If your doctor says that you need a fast coverage decision, we will automatically give you one.

    - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.

        - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.

        - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.

        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagrees with our decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call the Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The Senior HelpLine is not connected with us or with any insurance company or health plan. The call and help are free.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 65 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a Medicaid service you currently get will be changed or stopped, you have **10 calendar days** to appeal if you want to keep getting that Medicaid service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. For additional details on how to reach us for appeals, refer to Chapter 2 , Section A.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
    - You can submit a request to the following address:

      Meridian Medicare-Medicaid Plan (MMP)
      Attn: Appeals and Grievances – Medicare Operations
      P.O. Box 10450
      Van Nuys, CA 91410-0450
    - You may also ask for an appeal by calling us at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal

holidays, you may be asked to leave a message. Your call will be returned within the next business day.

> **The legal term** for "fast appeal" is **"expedited reconsideration."**

Can someone else make the appeal for me?

Yes. Your doctor, other provider, or someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at https://mmp.ilmeridian.com/content/mmp-il/enus/member/benefits-coverage/tools-resources/documents-and-forms.html.

If the appeal comes from someone besides you, we usually must get the completed Appointment of Representative form before we can review the appeal.

Note that under the Medicare program, your doctor or other provider can file an appeal without the Appointment of Representative form.

How much time do I have to make an appeal?

You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a Medicaid service you currently get will be changed or stopped, you have **10 calendar days** to appeal if you want to keep getting that Medicaid service while your appeal is processing. Read "Will my benefits continue during Level 1 Appeals" for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to find out if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 15 business days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J.
- If we do not give you an answer to your appeal within 15 business days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a service or item covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service or item covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 72 hours after we give you our answer (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about a service or item covered by Medicare or both Medicare and Medicaid, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a service or item covered only by Medicaid, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will let you know within 24 hours after we get your request if we need more information to decide your appeal. We will make a decision on your fast appeal within 24 hours after receiving all of the required information from you.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J.
- If we do not give you an answer to your appeal within 24 hours after receiving all required information or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a service or item covered by Medicare or both Medicare and Medicaid. You will be notified when this happens. If your problem is about a service or item covered only by Medicaid, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we make our decision.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about a service or item covered by Medicare or both Medicare and Medicaid, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a service or item covered only by Medicaid, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4.

Will my benefits continue during Level 1 Appeals?

- If your problem is about a service covered by Medicare or both Medicare and Medicaid, your benefits for that service will continue during the Level 1 Appeal process.
- If your problem is about a service covered only by Medicaid, your benefits for that service will not continue unless you ask the plan to continue your benefits when you appeal. You must submit your appeal and ask to continue benefits within 10 calendar days after you receive the Notice of Denial of Medical Coverage. If you lose the appeal, you may have to pay for the service.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

- If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.
- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medicaid** service or item, you can file a Level 2 Appeal yourself with the State Fair Hearings office. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. If they also say **No** to your appeal, you can ask for another Level 2 Appeal with the State Fair Hearings office.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. It is either an Independent Review Entity (IRE) or it is a Medicaid State Fair Hearings office. The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

Level 2 of the appeals process for Medicaid services is a State Fair Hearing. You must ask for a State Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 Appeal. The letter you get from us will tell you where to submit your hearing request.

- If you want to ask for a State Fair Hearing about a standard Medicaid item or service, the Aging Waiver (Community Care Program, or CCP), or the Supportive Living Facilities Waiver, submit your appeal in writing or over the phone to:

MAIL	Illinois Healthcare and Family Services Bureau of Administrative Hearings Fair Hearings Section 69 West Washington, 4th Floor Chicago, Illinois 60602
CALL	855-418-4421 (toll free)
TTY	877-734-7429
FAX	312-793-2005
EMAIL	HFS.FairHearings@Illinois.gov

- If you want to ask for a State Fair Hearing about the Persons with Disabilities Waiver, Traumatic Brain Injury Waiver, or the HIV/AIDS Waiver (Home Services Program, or HSP), submit your appeal in writing or over the phone to:

MAIL	Department of Human Services Bureau of Hearings 69 West Washington, 4th Floor Chicago, Illinois 60602
CALL	800-435-0774 (toll free)
TTY	877-734-7429
FAX	312-793-3387
EMAIL	DHS.BAH@illinois.gov

The hearing will be handled by an Impartial Hearing Officer authorized to oversee State Fair Hearings.

- You will get a letter from the Hearings office telling you the date, time, and place of the hearing. This letter will also provide detailed information about the hearing. It is important that you read this letter carefully.
- At least three business days before the hearing, you will get a packet of information from our plan. This packet will include all the evidence we will present at the hearing. This packet will also be sent to the Impartial Hearing Officer.

- You will need to tell the Hearings office of any reasonable accommodations you may need.
- If because of your disability you cannot participate in person at the local office, you may ask to participate by phone. Please provide the Hearings staff with the phone number to best reach you.
- You must provide all the evidence you will present at the hearing to the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear, as well as all documents you will use.
- The hearing will be recorded.

My problem is about a service or item that is covered by Medicare or both Medicare and Medicaid. What will happen at the Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicare or both Medicare and Medicaid, you will **automatically** get a Level 2 Appeal from the Independent Review Entity (IRE). The IRE will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will

tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

How will I find out about the decision?

If your Level 2 Appeal was a State Fair Hearing, the State Fair Hearings office will send you a letter explaining its decision. This letter is called a "Final Administrative Decision."

- If the State Fair Hearings office says **Yes** to part or all of what you asked for, we must authorize or provide the medical care coverage as soon as your health requires.
- If the State Fair Hearings office says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal went to the State Fair Hearings office, and you disagree with the decision, you cannot make another appeal on the same issue to the State Fair Hearings office. The decision is reviewable only through the Circuit courts of the State of Illinois.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you may be able to appeal again in certain situations:

- If your problem is about a service or item that is covered by **both Medicare and Medicaid**, you can ask for another Level 2 Appeal with the State Fair Hearings office.

After the IRE makes its decision, we will send you a letter telling you about your right to ask for a State Fair Hearing. Refer to page 176 for information on the State Fair Hearing process.

- If your problem is about a service or item that is covered by **Medicare or both Medicare and Medicaid**, you can appeal after Level 2 only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I for more information on your appeal rights after Level 2.

Will my benefits continue during Level 2 appeals?

Maybe.

- If your problem is about a service covered by Medicare only, your benefits for that service will **not** continue during the Level 2 appeals process with the IRE.
- If your problem is about a service covered by Medicaid only, your benefits for that service will continue if you submit a Level 2 Appeal within 10 calendar days after receiving the plan's decision letter.
- If your problem is about a service covered by both Medicare and Medicaid, your benefits for that service will continue during the Level 2 appeal process with the IRE. If you submit the appeal to the State Fair Hearings office after the IRE makes its decision and you would like for your services to stay in place during the State Fair Hearing process, you must ask for them to remain in place and you must ask within 10 calendar days of the notice from the IRE.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs" in the section titled "When a network provider sends you a bill." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check to find out if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request. If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare or both Medicare and Medicaid, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid only, you can file a Level 2 Appeal yourself (refer to Section E4).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

The *Drug List*, includes some drugs with a "NT". These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with a "NT" symbol follow the process in Section E.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's *Drug List*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's *Drug List* but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our *Drug List* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with Section F2. Also refer to Sections F3 and F4.	Skip ahead to Section F4.	Skip ahead to Section F4.	Skip ahead to Section F5.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our *Drug List* or to use the drug without certain rules and limitations. If a drug is not on our *Drug List* or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *Drug List*.
    - You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our *Drug List* (for more information, refer to Chapter 5, Section C).
    - The extra rules and restrictions on coverage for certain drugs include:

- Being required to use the generic version of a drug instead of the brand name drug.
- Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization” (PA).)
- Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- Quantity limits. For some drugs, we limit the amount of the drug you can have.

> **The legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our *Drug List* includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

At a glance: How to ask for a Coverage Decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function**.

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-580-1689 (TTY: 711).
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 65 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 65 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this chapter section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4.

> **The legal term** for "fast appeal" is **"expedited redetermination."**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to find out if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."

- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- You have a right to give the IRE other information to support your appeal.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

> **The legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The “Important Message” tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On

weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you. In Illinois, the Quality Improvement Organization is called Livanta BFCC-QIO.

To make an appeal to change your discharge date call Livanta BFCC-QIO at: 1-888-524-9900 (TTY: 1-888-985-8775).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. “An Important Message from Medicare about Your Rights” contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for a “fast review”.

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call the Senior HelpLine Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966 (TTY: 1-888-206-1327). The call and help are free.

What is a Quality Improvement Organization?

It is a group of doctors and other healthcare professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> **The legal term** for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> **The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Illinois, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: **1-888-524-9900 (TTY: 1-888-985-8775).**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.” The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Or call the Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Illinois, the Quality Improvement Organization is called Livanta BFCC_QIO. You can reach Livanta BFCC_QIO at: 1-888-524-9900 (TTY: 1-888-985-8775). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-88-985-8775) and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4.

The legal term for the written notice is **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or refer to the copy online www.cms.gov/Medicare/Medicare-General-Information/BNI.

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is **“Detailed Explanation of Non-Coverage.”**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Illinois, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: 1-888-524-9900 (TTY: 1-888-985-8775). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.

- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

I. Taking your appeal beyond Level 2

I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Senior HelpLine Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966 (TTY: 1-888-206-1327). The call and help are free.

I2. Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid.

After your Level 2 Appeal in the State Fair Hearings office has concluded, you will get a written decision called a "Final Administrative Decision." This decision is made by the Director of the Agency based on recommendations from the Impartial Hearing Officer. The decision will be sent to you and all interested parties in writing by the Hearings office. This decision is reviewable only through the Circuit courts of the State of Illinois. The time the Circuit Court will allow for filing for such review may be as short as 35 days from the date of your Final Administrative Decision.

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Meridian Medicare-Medicaid Plan (MMP) staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> **The legal term** for a "complaint" is a **"grievance."**
>
> **The legal term** for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Senior HelpLine at 1-800-252-8966 (TTY: 1-888-206-1327), Monday through Friday from 8:30 a.m. to 5:00 p.m. The call and help are free.

J2. Internal complaints

- To make an internal complaint, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.

- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. A grievance (complaint) can be submitted in writing by mail or fax. Send your request to:

  Meridian Medicare-Medicaid Plan (MMP)
  Attn: Appeals and Grievances – Medicare Operations
  P.O. Box 10450
  Van Nuys, CA 91410-0450
  Fax: 1-844-273-2671

  - An Expedited Grievance (fast complaint) is resolved within 24 hours. You can request an expedited grievance if you disagree with our decision to process your expedited request or appeal under normal time frames.
  - A Standard Grievance (complaint) is generally resolved within 30 days from the date we receive your request unless your health or condition requires a quicker response. Plans may take a 14-day extension if the enrollee requests the extension or if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee. Plans must promptly notify the enrollee in writing if the extension is going to be taken and explain the reason for the delay.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell the Illinois Department of Healthcare and Family Services about your complaint

To file a complaint with the Illinois Department of Healthcare and Family Services, send an email to Aging.HCOProgram@illinois.gov.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Address:

Office for Civil Rights

U.S. Department of Health and Human Services

233 N. Michigan Ave, Suite 240

Chicago, IL 60601

Contact Information for the Customer Response Center:

Phone: 1-800-368-1019

TTY: 1-800-537-7697

Fax: 1-202-619-3818

You may also have rights under the Americans with Disability Act and under the Illinois Human Rights Act. You can contact the Senior HelpLine for assistance Monday through Friday from 8:30 a.m. to 5:00 p.m. The phone number is 1-800-252-8966, TTY: 1-888-206-1327. The call and help are free.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section F.

In Illinois, the Quality Improvement Organization is called Livanta BFCC-QIO. The phone number for Livanta BFCC_QIO is 1-888-524-9900 (TTY: 1-888-985-8775).

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. When you can end your membership in our Medicare-Medicaid Plan

You can ask to end your membership in Meridian Medicare-Medicaid Plan (MMP) at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

If you want to return to getting your Medicare and Medicaid services separately:

- Your membership will end on the last day of the month that Illinois Client Enrollment Services or Medicare gets your request to change your plan. Your new coverage will begin the first day of the next month. For example, if Illinois Client Enrollment Services or Medicare gets your request on January 18th, your new coverage will begin February 1st.

If you want to switch to a different Medicare-Medicaid Plan:

- If you ask to change plans before the 18th of the month, your membership will end on the last day of that same month. Your new coverage will begin the first day of the next month. For example, if Illinois Client Enrollment Services gets your request on August 6th, your coverage in the new plan will begin September 1st.
- If you ask to change plans after the 18th of the month, your membership will end on the last day of the following month. Your new coverage will begin the first day of the month after that. For example, if Illinois Client Enrollment Services gets your request on August 24th, your coverage in the new plan will begin October 1st.

If you leave our plan, you can get information about your:

- Medicare options in the table in Section D1.
- Medicaid services in the table in Section D2.

You can get more information about when you can end your membership by calling:

- The Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m., Monday through Friday. TTY users should call 1-866-565-8576.
- The Senior Health Insurance Program (SHIP) at 1-800-252-8966, from 8:30 a.m. to 5 p.m., Monday through Friday. TTY users should call 1-888-206-1327.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to Chapter 5 of your *Member Handbook* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Medicaid or Medicare that you want to leave Meridian Medicare-Medicaid Plan (MMP):

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m. Monday through Friday. TTY users should call 1-866-565-8576; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in Section D1.

C. How to join a different Medicare-Medicaid Plan

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call Illinois Client Enrollment Services at 1-877-912-8880, from 8 a.m. to 6 p.m. Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Meridian and join a different Medicare-Medicaid plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.
- If Illinois Client Enrollment Services gets your request before the 18th of the month, your coverage with Meridian will end on the last day of that same month. If Illinois Client Enrollment Services gets your request after the 18th of the month, your coverage with Meridian will end on the last day of the following month.

D. How to get Medicare and Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Meridian Medicare-Medicaid Plan (MMP), you will return to getting your Medicare and Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE) **This chart is continued on the next page**	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: ● Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 1-888-206-1327. The call and help are free. You will automatically be disenrolled from Meridian Medicare-Medicaid Plan (MMP) when your new plan's coverage begins.

(continued) **2. You can change to:** **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 1-888-206-1327. The call and help are free. You will automatically be disenrolled from Meridian Medicare-Medicaid Plan (MMP) when your Original Medicare coverage begins.
3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call your Senior Health Insurance Program (SHIP) at 1-800-252-8966. TTY users should call 1-888-206-1327.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Senior Health Insurance Program (SHIP) at 1-800-252-8966 Monday through Friday from 8:30 a.m. to 5 p.m. TTY users should call 1-888-206-1327. The call and help are free. You will automatically be disenrolled from Meridian Medicare-Medicaid Plan (MMP) when your Original Medicare coverage begins.

D2. How to get your Medicaid services

If you leave the Medicare-Medicaid Plan, you will either get your Medicaid services through fee-for-service or be required to enroll in the HealthChoice Illinois Managed Long-Term Services and Supports (MLTSS) program to get your Medicaid services.

If you are not in a nursing facility or enrolled in a Home and Community-Based Services (HCBS) Waiver, you will get your Medicaid services through fee-for-service. You can use any provider that accepts Medicaid and new patients.

If you are in a nursing facility or are enrolled in an HCBS Waiver, you will be required to enroll in the HealthChoice Illinois MLTSS program to get your Medicaid services.

To choose a HealthChoice Illinois MLTSS health plan, you can call Illinois Client Enrollment Services at 1-877-912-8880 from 8 a.m. to 6 p.m. Monday through Friday. TTY users should call 1-866-565-8576. Tell them you want to leave Meridian and join a HealthChoice Illinois MLTSS health plan.

After you are enrolled in a HealthChoice Illinois MLTSS health plan, you will have 90 days to switch to another HealthChoice Illinois MLTSS health plan.

You will get a new Member ID Card, a new *Member Handbook*, and information about how to access the *Provider and Pharmacy Directory* from your HealthChoice Illinois MLTSS health plan.

E. Keep getting your medical items, services and drugs through our plan until your membership ends

If you leave Meridian Medicare-Medicaid Plan (MMP), it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, keep getting your prescription drugs and healthcare through our plan.

- Use our network providers to receive medical care.
- **Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in Meridian Medicare-Medicaid Plan (MMP) ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when Meridian Medicare-Medicaid Plan (MMP) must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid. If you no longer qualify, you will be automatically disenrolled from Meridian by the state of Illinois.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to prison.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.

- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week. You should also call the Illinois Department of Healthcare and Family Services Health Benefits Hotline at 1-800-226-0768 8 a.m. to 4:30 p.m., Monday through Friday. TTY users should call 1-877-204-1012.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9, Section J for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Meridian Medicare-Medicaid Plan (MMP). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey the laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights.

  Address:

  Office for Civil Rights

  U.S. Department of Health and Human Services

  233 N. Michigan Ave, Suite 240

  Chicago, IL 60601

  Contact Information for the Customer Response Center:

  Phone: 1-800-368-1019

  TTY: 1-800-537-7697

  Fax: 1-202-619-3818

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Meridian Medicare-Medicaid Plan (MMP)as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers' Compensation has to pay first.

Meridian has the right and the responsibility to collect payment for covered services when someone else has to pay first.

C1. Meridian's right of subrogation

Subrogation is the process by which Meridian gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation

If an insurer other than Meridian should pay for services related to an illness or injury, Meridian has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by Meridian will be secondary when another plan, including another insurance plan, provides you with coverage for health care services.

C2. Meridian's right of reimbursement

If you get money from a lawsuit or settlement for an illness or injury, Meridian has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

C3. Your responsibilities

As a member of Meridian, you agree to:

- Let us know of any events that may affect Meridian's rights of Subrogation or Reimbursement.
- Cooperate with Meridian when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help Meridian with its rights to Subrogation and Reimbursement.

- Authorize Meridian to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.
- Pay all such amounts to Meridian recovered by lawsuit, settlement or otherwise from any third person or their insurer to the extent of the benefits provided under the coverage, up to the value of the benefits provided.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Patient confidentiality and notice about privacy practices

We will ensure that all information, records, data and data elements related to you, used by our organization, employees, subcontractors and business associates, shall be protected from unauthorized disclosure pursuant to 305 ILCS 5/11-9, 11-10, and 11-12; 42 USC 654(26); 42 CFR Part 431, Subpart F; and 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Member Services at 1-855-580-1689 (TTY: 711). Hours are from Monday through Friday, 8 a.m. to 8 p.m. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Our Notice of Privacy Practices can be obtained by visiting www.mmp.ilmeridian.com/notice-of-privacy.html or by selecting the "Notice of Privacy Practices" link at the bottom of our webpage at mmp.ILmeridian.com. For more information on our Privacy Policy, please see Chapter 8, Section C2, page 145.

E. Independent Contractors

The relationship between Meridian Medicare-Medicaid Plan (MMP) and contracted participating providers is that of independent contractors. Participating providers are not employees or agents of Meridian Medicare-Medicaid Plan (MMP) Health Plan and neither Meridian Medicare-Medicaid Plan (MMP), nor any employee of Meridian Medicare-Medicaid Plan (MMP), is an employee or agent of a participating provider. In no event shall anything be taken to establish an employer/employee or principal/agent relationship or any fiduciary or other relationship other than independent parties contracting with each other. Participating providers are solely responsible for any acts of negligence, malfeasance, misfeasance, nonfeasance or any other wrongful act or omission. Participating physicians, and not Meridian Medicare-Medicaid Plan (MMP), maintain the physician-patient

relationship with the member. Meridian Medicare-Medicaid Plan (MMP) is not a provider of health care.

F. Coordination of Benefits

In the event that you are entitled to benefits under this Member Handbook and also entitled to benefits under any other public or private contract or arrangement for health care coverage, such as an automobile or homeowner's insurance policy, benefits are not available under this Member Handbook unless and until the other health plan benefit(s) or insurance policy(ies) are exhausted. Meridian Medicare-Medicaid Plan (MMP) will coordinate with other health care benefit plans in accordance with state and federal law.

G. Third Party Liability

Each time Meridian Medicare-Medicaid Plan (MMP) pays you or someone else on your behalf for health care services, we are entitled to be fully subrogated to all rights you may have against anyone (including but not limited to individuals, insurers or other entities) who may be responsible to pay for the health care services provided to you related to that illness, condition or injury. Meridian Medicare-Medicaid Plan (MMP) has a lien on any award, settlement or other recovery you may receive related to an illness, condition or injury where Meridian Medicare-Medicaid Plan (MMP) has made any payment on your behalf or to you. Common sources for this lien are settlements, awards or other recoveries from other insurers, such as automobile or workers' compensation, or proceeds from a personal injury, defective device, or other tort lawsuit.

If Meridian Medicare-Medicaid Plan (MMP) paid your doctors for health care services but you later receive compensation related to your injury, condition or illness, you are required to repay Meridian Medicare-Medicaid Plan (MMP) for what we paid to you or your doctors on your behalf, regardless of whether Meridian Medicare-Medicaid Plan (MMP) is required to seek subrogation. Additionally, while your claim for payment from a third party is pending or in dispute, Meridian Medicare-Medicaid Plan (MMP) may conditionally pay for health care services on your behalf. Payments like these are merely conditional and you must repay Meridian Medicare-Medicaid Plan (MMP) when you receive a payment from the third party related to the illness, condition or injury.

You are required to cooperate with Meridian Medicare-Medicaid Plan (MMP) as we seek to enforce our rights. This means that we, or a third party on our behalf, may send you questionnaires regarding injuries that you may experience, ask you for information or documentation related to a specific condition, illness or injury or the status of any recovery, and require you to participate at various stages of legal action where we or our attorneys attempt to enforce our lien.

Meridian Medicare-Medicaid Plan (MMP) does not waive any right to any recovery hereunder regardless of whether Meridian seeks to enforce its rights through subrogation, or repayment, or

does not seek to enforce its rights. Meridian Medicare-Medicaid Plan (MMP) has no obligation to seek subrogation or reimbursement on its own or your behalf.

H. Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by, for example, filing a claim that contains a false or deceptive statement is guilty of health care plan fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-866-364-1350 (TTY: 711). The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

I. Circumstances beyond Meridian Medicare-Medicaid Plan (MMP)'s control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in Meridian Medicare-Medicaid Plan (MMP)'s facilities or personnel not being available to provide or arrange for services or benefits under this *Member Handbook*, Meridian Medicare-Medicaid Plan (MMP)'s obligation to provide such services or benefits shall be limited to the requirement that Meridian Medicare-Medicaid Plan (MMP) make a good-faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called “aid paid pending.”

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9, Section D explains appeals, including how to make an appeal.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also “Original Biological Product” and “Biosimilar”).

Biosimilar: A biological product that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (See “Interchangeable Biosimilar”).

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan developed by you and your care coordinator that describes what medical, behavioral health, social and functional needs you have and identifies goals and services to address those needs.

Care team: A care team, led by a care coordinator, may include doctors, nurses, counselors, or other professionals who are there to help you build a care plan and ensure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, Section D explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our *Drug List*. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the *Drug List* is in one of three tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child’s

physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health assessment: A review of an enrollee’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.

- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

- Meridian must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Meridian Medicare-Medicaid Plan (MMP) Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because Meridian Medicare-Medicaid Plan (MMP) pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

***List of Covered Drugs* (*Drug List*):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports include Long-Term Care and Home and Community-Based Service (HCBS) waivers. HCBS waivers can offer services that will help you stay in your home and community.

Low-income subsidy (LIS): Refer to "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and drugs not covered by Medicare.

- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2, Section H for information about how to contact Medicaid in your state.

Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Illinois Medicaid coverage rules.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual.”

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Meridian Medicare-Medicaid Plan (MMP) includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2, Section A for information about how to contact Member Services.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information about the ombudsman in Chapter 2, Section J and Chapter 9, Section A of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9, Section D explains how to ask us for a coverage decision.

Original Biological Product: A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out--of--network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: Refer to “Medicare Part A.”

Part B: Refer to “Medicare Part B.”

Part C: Refer to “Medicare Part C.”

Part D: Refer to “Medicare Part D.”

Part D drugs: Refer to “Medicare Part D drugs.”

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Meridian's Notice of Privacy Practices for more information about how Meridian protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems.

- They make sure you get the care you need to stay healthy. They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3, Section D1 for information about getting care from primary care providers.

Prior authorization (PA): An approval from Meridian you must get before you can get a specific service or drug or use an out-of-network provider. Meridian may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

- Covered services that need PA are marked in the Benefits Chart in Chapter 4, Section D.

Some drugs are covered only if you get PA from us.

- Covered drugs that need PA are marked in the *List of Covered Drugs* and the rules are posted on the plan website.

Prosthetics and orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2, Section F for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, Meridian may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3, Section D and about services that require referrals in Chapter 4, Section D.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to Chapter 4, Section D to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get Meridian.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The Illinois Department of Healthcare and Family Services.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers or you cannot get to them because given your time, place or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

Meridian Member Services

CALL	1-855-580-1689 Calls to this number are free. Representatives are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Representatives are available Monday-Friday, 8 a.m. to 8 p.m. to assist you. On weekends and on state or federal holidays, you may be asked to leave a message. Your call will be returned within the next business day.
FAX	1-833-415-2232
WRITE	Meridian Medicare-Medicaid Plan (MMP) 1333 Burr Ridge Parkway, Suite 100 Burr Ridge, IL 60527
WEBSITE	mmp.ILmeridian.com