

MEMBER HANDBOOK

MEMBER SERVICES: 312-864-8200 711 (TTY/TDD)



WELCOME TO COUNTYCARE

We are happy to have you as a member of CountyCare. We are committed to treating you with respect and getting you and your family the health care you need.

CountyCare wants to support you in a healthy lifestyle and asks you to be an active participant in your health. Your health care team will include your primary care provider (PCP), specialty providers, care coordinators, your pharmacist, and you.

CountyCare staff is available at 312-864-8200 Monday through Friday from 8:00 AM to 6:00 PM; and Saturday 9:00 AM to 1:00 PM (Central Time) to answer your questions. You can also call our nurse advice line 24 hours a day, every day of the year, with any questions you may have about your health. Our main goal is to make sure you receive high-quality health care.

This handbook tells you about your medical benefits. We would like you to read everything in this packet and write down any questions you have. It explains:

- How to get health care services
- What your benefits are
- Your rights and responsibilities as a member
- Contact information so you know who to call

The Certificate of Coverage is available at www.countycare.com or by calling 312-864-8200 and requesting a copy from Member Services.

We look forward to partnering with you to meet all of your health care needs.



IMPORTANT PHONE NUMBERS & CONTACTS

CountyCare's normal business hours of operation are
Monday–Friday: 8:00 AM to 6:00 PM (Central Time)
Saturday: 9:00 AM to 1:00 PM

Emergency	911
Member and Provider Services	312-864-8200 855-444-1661 (toll-free) 711 (TDD/TTY)
Member Services Fax	312-548-9940
Provider Services Fax	312-548-9940
24 Hour Nurse Advice Line	312-864-8200 (option 4, option 9)
Transportation	312-864-8200 (option 4, option 5)
Dental Benefits	312-864-8200 (option 4, option 3)
Vision Benefits	312-864-8200 (option 4, option 4)
Pharmacy Benefits	312-864-8200 (option 4, option 6)
Website	www.countycare.com

Please call us if you need help understanding this handbook or need it in a different language or format, such as Spanish, Polish, large print, Braille, audio tape, or CD.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 312-864-8200 / 855-444-1661 / 711 (TTY).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 312-864-8200 / 855-444-1661 / 711 (TTY).

After Hours & Holidays

When you need medical advice, you should first call your CountyCare PCP because they have access to your medical records and can give you personalized advice. If you cannot reach your PCP, you can call CountyCare's nurse advice line. This is our 24-hour, nurse on-call phone line, which can be reached at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). It is staffed with nurses who can assist you in any language that you may need.

Hearing Impaired Members

Call Illinois Relay at 711. Ask the operator to connect you to us at: 312-864-8200 or 855-444-1661 (toll-free).

Let your doctor know if you need a sign language interpreter for a medical visit. If your doctor does not have one, call us at least seven days before your visit to make arrangements for an interpreter to be present during your appointment.

Accessibility

If you use a wheelchair, walker or other aids and you need assistance getting into your doctor's office, call the office before you get there. This way someone will be ready to help you when you arrive.

Language Help

CountyCare offers language help 24 hours a day, seven days a week. This includes holidays and weekends.

If your doctor does not speak your language or does not have someone who can talk to you in a way that you can understand, please contact CountyCare for help. With seven days' notice before your appointment, we can schedule an interpreter to go with you on your next visit.

For help translating your health coverage benefits and available services, or for assistance with any questions, please call 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

Spanish

Para ayudar a traducir su cobertura de beneficios de salud y los servicios disponibles, o para ayudar con cualquiera pregunta, llame al 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

Other

This member handbook is also available in Spanish and Polish. For a hard copy, please call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Communication from CountyCare

As a valued CountyCare member, you will hear from us regularly. This will include:

- A copy of this handbook when you become a CountyCare member
- A phone call from us to conduct a health risk screening
- A newsletter mailed to your home every four months.

You may also get e-mail, texts or phone calls reminding you of needed exams.

Our staff will always identify themselves when we call you or return your calls.

It is important to keep CountyCare and your Department of Human Services (DHS) office informed of your address and phone number so we can make sure you get the information you need.

CountyCare's Website

CountyCare's website helps you get answers. Our website has resources, information, and features that make it easy for you to get quality care, such as:

- Member handbook (evidence of coverage/contract)
- Provider directory
- Current news
- Member self-service features
- Online form submissions
- Health information
- Information on CountyCare programs and services

Our website address is: www.countycare.com

CountyCare's Secure Member Portal

CountyCare has a secure member portal where you can:

- Change your PCP
- Print a temporary ID card
- Send/receive secure messages to/from CountyCare through our secure messaging system
- Get personalized health information
- View your care plan if you have one

In order to sign up for our secure member portal, go to www.countycare.com. From here, you will be able to set up your portal account. All you need is your member ID number, which is found on your CountyCare member ID card.

TABLE OF CONTENTS

Member Services	4	Managed Long-Term Services and Supports (MLTSS) Covered Services	19
Member ID Card	5	Dental Services	19
Open Enrollment	5	Vision Services	19
Access to Care	6	Behavioral Health & Substance Use Services	20
Provider Network	7	Family Planning Services	20
Primary Care Provider (PCP)	7	Pregnancy/Maternity Services	21
Women's Health Care Provider	7	Brighter Beginnings Program	21
How to Change Your PCP	7	Pharmacy Services	22
Continuity & Transition of Care	9	Transportation Services	22
Specialty Care	9	Ambulance Transportation	22
If You Need Care Immediately	9	Care Coordination	23
Emergency Care	9	Population Health Management Programs	23
Post Stabilization Care	10	Care Management Member Rights & Responsibilities	24
24 Hour Nurse Advice Line	10	Quality Improvement Program	26
Out of State Care	10	Recipient Restriction Program	26
Out of Network Care	11	Advance Directives	26
Preventive Services	11	Grievance & Appeals	27
Cost Sharing	13	Rights & Responsibilities	32
Covered Medical Services	14	Fraud, Waste and Abuse	34
Limited Covered Services	14	Health, Safety, Welfare, Reporting and Follow-Up of Incidents	35
Non-Covered Services	15	Definitions	37
CountyCare Member Extra Benefits	15	Disclaimers	38
Covered Home & Community Based Services (HCBS or "Waiver Services")	17	CountyCare Notice of Privacy Practices	39
Long Term Care	18		

COUNTYCARE MEMBER SERVICES

Welcome to CountyCare.

Our Member Services Department is ready to help you get the most from your health plan.

Member Services Phone Number: 312-864-8200

Hours of Operation: Monday through
Friday: 8:00 AM to 6:00 PM
Saturday: 9:00 AM to 1:00 PM

CountyCare wants to ensure you have all the information you need about your health plan. You can contact Member Services to find out the following information:

- Your benefits, including all the extra member incentives that CountyCare offers
- How to receive health care services
- Update your contact information
- Request a new ID card
- Change your PCP
- Authorizations needed for any health care services
- Nurse advice line
- How to receive emergency services
- How to receive post-stabilization services
- Your rights and responsibilities as a CountyCare member
- How to submit a grievance and an appeal
- Fair hearing procedures
- CountyCare's web address and the basic information included online
- Our Certificate of Coverage, which explains that we are contracted by the State of Illinois
- Our affiliated providers
- Ask questions or obtain information

Most of this information is also in this handbook. You can find additional information on the CountyCare website: www.countycare.com. If at any time you need assistance with this information, or would like to request additional information, please contact CountyCare Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). CountyCare will notify you every year of your right to receive this basic information.

You can contact CountyCare 24 hours a day, seven days a week through our 312-864-8200 toll-free number. You can verify eligibility and reach our nurse advice line any time of day or night.

Expect a Welcome Call from Us

A CountyCare representative will call to welcome you to CountyCare in your first 30 days. They will also answer any of your questions and ask you to complete a health risk screening.

New Enrollee Transition of Care

If you are new to CountyCare and being treated by a health care provider who is not a CountyCare provider, you can keep seeing that provider for up to 90 days after joining our plan. We will honor all services as long as the provider is Medicaid Certified and the services are medically necessary. The provider must also agree to accept our payment.

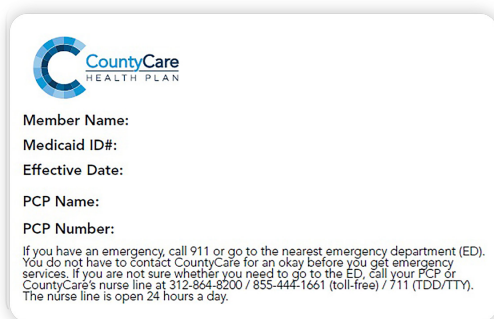
Please let us know of any non-CountyCare providers you are seeing. We need to know so that we can make arrangements to pay for your services and try to contract with them so you can continue to see them after 90 days.



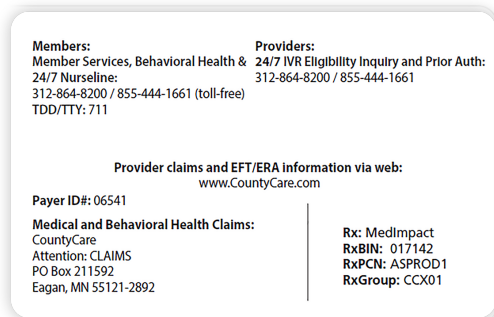
MEMBER IDENTIFICATION (ID) CARD

Your member ID card is in your welcome packet. Please check your ID card to make sure the information is correct. If your member ID card is not in your welcome packet please call Member Services at 312-864-8200, TTY 711.

Always carry your CountyCare card with you. Show it every time you get care. You may have problems getting care or prescriptions if you do not have your ID card with you. If you have other health coverage cards, bring them with you too.



Front of Card



Back of Card

Updating Your Address and Phone Number

It is very important to tell CountyCare, your case worker, and the Illinois Department of Human Services (DHS) if your address or phone number changes. Please notify CountyCare and give us your updated information. We can be reached at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) and the DHS Helpline can be reached at 800-843-6154.

OPEN ENROLLMENT

Once each year, you can change health plans during a specific time called "Open Enrollment." Illinois Client Enrollment Services (CES) will send you an open enrollment letter approximately 60 days prior to your anniversary date. Your anniversary date is one year from your health plan start date. You will have 60 days during your open enrollment to make a one plan switch by calling CES at 1-877-912-8880. You can also switch plans online by going to <https://enrollhfs.illinois.gov>. If you do not want to switch plans, you do not need to do anything and you will remain with CountyCare.

After the 60 days has ended, whether you switched plans or not, you will be locked in for 12 months.

If you have questions regarding your enrollment or disenrollment with CountyCare, please contact the Client Enrollment Service (CES) at 1-877-912-8880.

Redetermination – Keeping your Medicaid Coverage

Once a year you need to fill out the forms that the state sends you to make sure you keep your health care benefits for you and your family. If you need help in renewing your coverage or have questions about your forms, we can help. Call us at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). If you do not complete your redetermination or if you miss your renewal date, you may lose your coverage.

What Happens if I Lose my Coverage?

If you lose your Medicaid eligibility for 60 days or less and then become eligible again, you should be re-enrolled with CountyCare. We will reassign you to your past primary care provider (PCP) if that PCP is still accepting patients.

Member Satisfaction Surveys

Your satisfaction with CountyCare is very important to us. You may receive a survey in the mail or by telephone asking questions about how happy or unhappy you are with the services you are getting. Please take the time to respond. We value your opinion. It will help CountyCare to improve the service we provide.

Enrollee Advisory Committee

CountyCare invites our members to meet with us in person to share their opinions with us. During this meeting, members look at our materials and website and tell us what they think about our program. CountyCare uses this information to make program changes based on members' needs. If you want to be a part of our Enrollee Advisory Committee, call us at 312- 864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

ACCESS TO CARE

CountyCare works to provide you with timely access to health care. We work with our providers to follow quality standards. These standards set a reasonable amount of time for providers to see you once you request an appointment.

Scheduling Appointments

It is very important that you keep all appointments you make for doctor visits, lab tests, or x-rays. If you need help in making an appointment, please contact Members Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

When you need care, call your PCP first. Your PCP will help you manage all of your health services. If you think you need to see a specialist or another provider, talk with your PCP. Your PCP can help you decide if you need to see another provider. You do not need a referral from your PCP for mental health or substance use treatment.

Network providers will be open at reasonable times. You will get an appointment based on your medical needs. You should be given an appointment within the time frames below.

IMPORTANT: If you cannot keep an appointment, please call the doctor's office to cancel at least 24 hours in advance. If you need to change an appointment, call the doctor's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Member Services at 312-864-8200 /855-444-1661 (toll-free) / 711 (TDD/TTY).

PCP After Hours

PCPs have 24-hour answering services or they have a telephone recording. The answering services or recording will instruct you on how to receive care after regular office hours.

If you have a medical problem or question and cannot reach your PCP during normal office hours, you can call CountyCare's 24-hour nurse advice line at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) to speak to a nurse. If you have an emergency, call 911 or go to the nearest emergency department (ED).

Time/Distance to Care

CountyCare members can access primary care within 30 minutes or 30 miles in urban areas and 60 minutes or 60 miles in rural areas. CountyCare members can call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) for help finding a PCP within their area. A member may choose to travel beyond the distance standards when selecting a PCP or specialty care provider.

PCP APPOINTMENT TYPE	ACCESS STANDARD
Routine visit	Within 5 weeks
Non-urgent visit	Within 3 weeks
Urgent-care visit	Within 24 hours
Emergency visit	Immediately, 24 hours a day, 7 days a week and without prior authorization.
Initial Visit, Pregnant Women	1 st Trimester: 2 weeks 2 nd Trimester: 1 week 3 rd Trimester: 3 days
After-hours coverage	24 hours per day, 7 days per week
Office wait times	Within one hour of scheduled appointment

Homebound Members

If a member is homebound or has significant mobility limitations, CountyCare will provide access to care through home visits by an appropriately licensed health care provider. Contact CountyCare if you require this service.

PROVIDER NETWORK

A provider network is a list of the doctors, specialists, clinics and hospitals that health plans contract with to provide health care to members. CountyCare has a large network of providers that you can choose from. You can see who is in our network by going online to www.countycare.com/find-a-provider. The provider directory displays each provider's name, address, telephone number, office hours, board certification status, and languages spoken. You can call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TTD/TTY) and they can assist you in finding a provider or to request a printed copy be mailed to you. The provider directory is also available in a printable PDF for viewing on our website.

PRIMARY CARE PROVIDER (PCP)

Every CountyCare member has a primary care provider (PCP). Your PCP is your personal doctor. You should see your PCP for all of your routine care and screenings. We ask you to call your PCP first when you are sick, unless it is an emergency. You will be referred to your assigned PCP's office if you call to make an appointment with someone other than the PCP listed on your CountyCare member ID card.

If your preferred PCP is not listed on your ID card, you can change it at any time.

If needed, a specialist can also be your PCP. However, in order for a specialist to be your PCP, he/she needs to agree to provide you with that level of care, and CountyCare has to approve it. Please contact Member

Services if you wish to proceed with your specialist as your PCP by calling 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

If you are an American Indian/Alaskan Native member, you have the right to get services from an Indian Tribe, Tribal Organization or Urban Indian Organization provider in and outside of the State of Illinois.

If you need help in finding or changing your PCP, please contact Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

WOMEN'S HEALTH CARE PROVIDER (WHCP)

As a woman with CountyCare coverage, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor, advanced practice nurse (APN) or physician assistant (PA), licensed and certified to practice in obstetrics (OB), gynecology (GYN) or family practice.

You can choose a WHCP as your primary care provider or you can have a WHCP in addition to your PCP. You can go to any participating provider for routine preventive OB/GYN care. You do not need approval from CountyCare or a referral from your PCP.

HOW TO CHANGE PCPS

You can find your PCP on your member ID card. If the PCP listed on your card is not correct, or you want to switch doctors, you can do so at any time by contacting Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY). You can also log in to our secure member portal to change your PCP online or fill out the PCP Change Form that is available on our website at www.countycare.com.

A PCP change requested will be effective the 1st of the following month. For example, change requests received January 1st – 31st are effective February 1st.



PCP Change Request Form

Member Info

First/MI/Last: _____
 Address: _____
 City: _____ Zip: _____
 DOB: _____ SSN: _____
 Member ID: _____ Phone: _____

PCP Change Request

Requested PCP Name: _____
 Provider ID: _____
 Office Address: _____
 City: _____ Zip: _____
 Office Phone: _____
 Effective Date: _____

Reason for Change From Assigned PCP

- Already patient with requested PCP
- Requested PCP already sees family member
- Member preference
- Member moved
- PCP hours didn't fit member's needs
- Quality of care
- Provider location
- Request a specialist as PCP
- Language/communication barriers
- Wait time in provider office
- Availability to get appointment/access to care
- Association with hospital or medical group
- Established relationship w/another
- Request a homebound provider as PCP
- Other

Signature of Member or Authorized Representative

Date

Printed Name of Authorized Representative

Directions: Please fax member change data forms, with a copy of the member ID card, if available, to CountyCare Health Plan Member Services department at 312-548-9940, or mail it to CountyCare Health Plan, P.O. Box 21153, Eagan, MN 55121. If the correct PCP is not listed on your card, or you wish to switch doctors, you may also call our Member Services department at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

If you have questions about how to complete this form, please call the CountyCare Health Plan Member Services department Monday through Friday, 8:00 AM – 6:00 PM, and Saturday, 9:00 AM – 1:00 PM, at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

CONTINUITY & TRANSITION OF CARE

If your provider leaves the CountyCare network while you are getting covered services from them, you may be able to keep getting some services from that provider. CountyCare will work with your provider to make a plan to cover the following situations.

- **Acute conditions.** Covered services for the duration of the condition.
- **Serious chronic conditions.** Covered services for a period of time, not to exceed 12 months from the date of the provider's termination.
- **Pregnancy care.** Covered services for the duration of the pregnancy, including immediate postpartum care.
- **Terminal illnesses.** Covered services for the duration of the illness.
- **Surgery or another procedure that is part of a course of treatment.** Covered services must be recommended and scheduled for within 180 days of the date of the provider's last day in network.

If your provider is not willing to participate in a plan of care for these situations, CountyCare will help you transfer to a new provider. To learn more call CountyCare's Member Services department at: 312-864-8200 / 855-444-1661 (toll free) / 711 (TDD/TTY).

SPECIALTY CARE

A specialist is a doctor who cares for you for a certain health condition. An example of a specialist is Cardiology (heart health) or Orthopedics (bones and joints). If your PCP thinks you need a specialist, he or she will work with you to choose a specialist. Your PCP will arrange your specialty care. In some cases, a specialty provider may be assigned as your PCP due to a chronic condition that you may have. However, in order for a specialist to be your PCP, he/she needs to agree to provide you with that level of care.

With CountyCare, you do not need a referral to see a specialist, but it is best to see your PCP first. Your PCP can advise you if a specialist is needed and recommend specialists for your specific health condition. If you need mental health services, you do not need a referral as long as you see a CountyCare provider. If you need help getting an appointment, please contact your care coordinator or Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

IF YOU NEED CARE IMMEDIATELY- WHAT TO DO AND WHERE TO GO

If you need care immediately, you should call your assigned primary care provider (PCP) listed on your Member ID card. These are cases where you need prompt attention but is not life-threatening. **Immediate care is not the same as emergency care.** Your PCP will see you within one business day or will tell you where to receive care.

Some examples include::

- Minor cuts and scrapes
- Sprains and minor injuries
- Fever
- Earache

You should ONLY go to the hospital emergency department (ED) for life-threatening situations or when your PCP advises you to go there. Call your PCP or our 24-hour Nurse Advice Line at 312-864-8200, 711 (TDD/TTY), and they will help you decide where to get care. If you need help finding a PCP or for questions, call Member Services at 312-864-8200, 711 (TDD/TTY).

EMERGENCY CARE

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness. If you have an emergency call 9-1-1 immediately.

Some examples of an emergency are:

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

What to do in case of an emergency:

- Go to the nearest emergency department; you can use any hospital to get emergency services
- Call 911
- Call ambulance if no 911 service is in the area
- No referral is needed
- Prior authorization is not needed, but as soon as your condition is stable, you should call your PCP to arrange follow-up care

POST-STABILIZATION CARE

Post-stabilization services are needed after an emergency medical condition. CountyCare covers these services. These services may be provided in the hospital, at home or in an office setting. For a list of providers or facilities providing these services, you may find providers listed on countycare.com/find-a-provider or you may call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). Your care coordinator can also help set up post-stabilization services.

If you have a condition that occurs often, talk to your PCP about making a medical emergency plan. If you must go to an out-of-network hospital or provider, call CountyCare as soon as you can and tell us what happened. This is important so we can help you get follow-up care.

24 HOUR NURSE ADVICE LINE

Everyone has questions about their health. The best person to call is your CountyCare provider because they have access to your medical records and can give you personalized advice. If you cannot reach your provider, you may call our nurse advice line.

- Receive medical advice over the phone from registered nurses
- Open 24 hours a day, every day of the year
- Get help in deciding where to go for care

Nurse line health topics:

- Advice on minor injuries
- Questions about glucose and insulin
- What to do about wounds
- How to deal with asthma
- How much medicine to use/give
- What to do if you have a headache
- Questions about pregnancy and baby issues

OUT OF STATE CARE

If you travel outside of Illinois and need emergency services, health care providers can treat you. They will send claims to us. You will be responsible for payment of any service you get outside Illinois if the provider will not send claims to us or will not accept our payment. Emergency services are covered only if these services are provided in the United States. Emergency services provided outside of the United States are not covered.

For urgent or routine care away from home, you must get approval from CountyCare to go to a different provider. Call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) to get this approval.

OUT OF NETWORK CARE

You must receive your care from in-network providers and hospitals. You may find a list of in-network providers and hospitals on countycare.com/find-a-provider or you may call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/

TTY). You must have approval from CountyCare if you go to out-of-network providers. The only exception is for treatment of emergencies, family planning services, school dental services and state operated hospitals.

PREVENTIVE SERVICES

CountyCare wants to help you get care before you get sick. The charts below show some of the preventive tests and exams adults and children

should get. You should consult with your doctor to determine which test is right for you and the most appropriate age to receive particular tests.

Preventive Services

EXAM	AGE	FREQUENCY
Checkup	Under Age 1	Birth, During first 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months
Checkup	Age 1-3	12 months, 15 months, 18 months, 24 months/30 months
Checkup	Age 3-6	Annually
Checkup	Age 6-21	Every other year, at a minimum, or more often if medically necessary
Checkup	Ages 22-65	Within the first year of enrollment and every 1-3 years thereafter, or as indicated by need and clinical care guidelines
Checkup	Over age 65	Annually
Clinical Breast Exam	Age 20-40	Every 1-3 years
Clinical Breast Exam	Over age 40	Annually

Preventive Care for Women

EXAM	AGE	FREQUENCY
Pelvic Exam	Under age 39	Every 3 years
Pelvic Exam	Age 40 & above	Annually
PAP	Age 21 & above	Every 3 years (Frequency depends on risk factors; ask your doctor)
Mammogram	Age 40-49	Consult with your doctor
Mammogram	Age 50-74	Annually

Additional Preventive Care

FEMALES	AGE	RECOMMENDED PREVENTIVE SERVICES
	21-26	<ul style="list-style-type: none"> Flu Vaccine (annually) Cervical Cancer Screening Human Papilloma Virus (HPV) Vaccine All Sexually Transmitted Infections Testing Tetanus-Diphtheria Booster (should receive every 10 years)
	27-49	<ul style="list-style-type: none"> Flu Vaccine (annually) Cervical Cancer Screening Cholesterol Testing (begin at 35 years old and at 5-year intervals thereafter) Type 2 Diabetes Screening (begin at 45 years old and every 3 years after) Tetanus-Diphtheria Booster (should receive every 10 years)
	50-64	<ul style="list-style-type: none"> Flu Vaccine (annually) Cholesterol Testing (begin at 35 years old and at 5-year intervals thereafter) Cervical Cancer Screening Colorectal Cancer Screening (begin at 50 years of age) Shingles (zoster) Vaccine (one dose at 60 years of age and older) Tetanus-Diphtheria Booster (should receive every 10 years)
65+	<ul style="list-style-type: none"> Pneumonia Vaccine 	

MALES	AGE	RECOMMENDED PREVENTIVE SERVICES
	21-26	<ul style="list-style-type: none"> Flu Vaccine (annually) Human Papilloma Virus (HPV) Vaccine All Sexually Transmitted Infections Testing Tetanus-Diphtheria Booster (should receive every 10 years)
	27-49	<ul style="list-style-type: none"> Flu Vaccine (annually) Cholesterol Testing (begin at 35 years old and at 5-year intervals thereafter) Type 2 Diabetes Screening (begin at 45 years old and every 3 years after) Tetanus-Diphtheria Booster (should receive every 10 years)
	50-64	<ul style="list-style-type: none"> Flu Vaccine (annually) Cholesterol Testing (at 5-year intervals) Colorectal Cancer Screening (begin at 50 years of age) Prostate Exam Shingles (zoster) Vaccine (one dose at 60 years of age and older) Tetanus-Diphtheria Booster (should receive every 10 years)
65+	<ul style="list-style-type: none"> Pneumonia Vaccine 	

Well Child Care

Preventive Care for Members Up To Age 21: Early and Periodic Screening, Diagnosis & Treatment (EPSDT)

EPSDT is a preventive health care program for persons ages birth to 21 years old. It is also called "well child care" or "routine checkups" based on recommended schedules for your child's age and health history. Five categories are covered under the EPSDT program and include the routine checkup, vision, hearing, dental, and developmental screenings. Children and young people need to see their doctor regularly even when they are not sick. We do not want your child to miss any key steps toward good health as they grow

Doctors and nurses will first examine your child or teen. They will give vaccines to prevent diseases when necessary. Vaccines are important to keep your child healthy. Doctors and nurses also check for common problems such as vision and hearing loss at appropriate intervals. Vision screenings are provided at visits annually from age 3 through 6 years, and again at ages 8, 10, 12, 15 and 18 years. Hearing tests are provided at the newborn visit and annually from age 4 to 6 and again at age 8 and 10 years.

Developmental screening tests to assess how your child is growing and developing is performed at 9 months, 18 months and 24/30 months of age. Autism screening should be conducted on your child at the 18 month and 24 month visits. Dental screening should also be performed prior to your child's third birthday. Separate blood tests may be ordered for lead screening at 12 and 24 months and over the age of 24 months up to age 7 if no lead screening test exists. Your child should receive the screen regardless of where they live. Doctors and nurses will also ask about concerns you or your child may have and support you to help your child stay healthy. If a problem is found during any part of the exam or screenings, your child's PCP can refer your child to a specialist.

To schedule an EPSDT visit, call your doctor. If you have problems scheduling your visit, please call Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

COST SHARING ("COPAYS")

With CountyCare you will not have any copays for your medical care or prescription drugs. This means that you should not get any bills for your CountyCare covered benefits or pre-authorized services. If you get a bill or statement by mistake, send it to the address below:

CountyCare Health Plan
P.O. Box 21153
Eagan, MN 55121

If you have any other problems with medical bills for CountyCare covered services, please call Member Services at 312-864-8200 / 855- 444-1661 (toll-free) / 711 (TDD/TTY) for help.

How CountyCare Makes Health Care Decisions

CountyCare providers and health care staff make decisions based on the care that is right for you and what is covered by your Medicaid benefits. This is called Utilization Management (UM). CountyCare does not reward providers for denying your care. CountyCare employees who make UM decisions are not rewarded for limiting your care.

You can call CountyCare if you have a question about your benefits, providers, or any service you have asked for or received. You can call Member Services at 312- 864-8200 or 855-444-1661 (toll-free) / 711 (TDD/TTY). We are open Monday-Friday, from 8:00 AM – 6:00 PM and Saturday, 9:00 AM – 1:00 PM. After normal business hours and on holidays, calls are forwarded to our after-hours service, seven days a week. Language assistance is available for members to discuss benefits and answer questions. When a CountyCare representative answers the phone, they will greet you by telling you their name, title and company.

COUNTYCARE COVERED SERVICES

CountyCare covers all medically necessary Medicaid covered services along with some additional benefits for our members. We cover the services at no cost to you. We have included a list of covered services in this handbook. You can also visit our website at www.countycare.com or call Member Services to receive a copy of our covered services.

Some services require prior authorization. Your provider will submit any needed prior authorizations.

Covered Medical Services

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

- Abortion services are covered by Medicaid (not CountyCare) by using your HFS Medical Card
- Advanced practice nurse services
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic coverage for 21 and over
- Dental services, including oral surgeons
- EPSDT services for enrollees under age 21
- Family planning services and supplies
- FQHCs, RHCs and other Encounter Rate Clinic visits
- Home health agency visits
- Hospital emergency department visits
- Hospital inpatient services
- Hospital ambulatory services
- Laboratory and x-ray services
- Medical supplies, equipment, prostheses and orthoses
- Mental health services
- Nursing care

- Nursing facility services
- Optical services and supplies
- Optometrist services
- Palliative and hospice services
- Pharmacy services
- Physical, occupational and speech therapy services
- Physician services
- Podiatric services
- Post-stabilization services
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health
- Subacute alcoholism and substance abuse service
- Transplants
- Transportation to secure covered services

New Technology

New technology can be used to improve your care. It also can help improve your health. It can be in the form of:

- Medical tests
- Mental health procedures
- Pharmacy technology
- Medical gadgets and more

The use of new technology will be reviewed by CountyCare's Medical Director and the Quality and Utilization Committees. New technology must meet CountyCare's guidelines to be accepted. These rules make sure that it is safe for you and that it will improve your health and quality of life.

LIMITED COVERED SERVICES

- Sterilization services as allowed by state and federal law. The provider must complete HFS Form 2189 and file it in the medical record.
- Hysterectomy if the provider completes HFS Form 1977 and files it in the medical record.

Well-Child Visits – \$10/\$50 reward

You can get rewards for taking your baby to the doctor in their first 15 months.

- \$50 for the first visit in the first month
- \$10 for the next five visits

Immunizations for Babies – \$10 reward

You get rewards for taking your baby for vaccinations before they turn 2 years old.

- \$10 for the first 10 immunizations

Mammography Program – \$25 reward

Women ages 50 to 74 can earn a \$25 reward each year when they get their mammogram

Managing Diabetes – \$25 reward

When a member with diabetes goes for their annual PCP visit and gets their blood tests and urine screens, CountyCare will add \$25 to their CountyCare OTC Rewards Card.

Aftercare/Follow-up Visits – \$10/\$20 reward

Members who follow up with their doctors after ER visits or inpatient stays will receive the following rewards:

- \$20 for seeing your doctor within 7 days after an emergency room visit for behavioral health; or
- \$10 if it is more than 7 days but within 30 days after an emergency room visit for behavioral health.
- \$20 for seeing your doctor within 7 days after an inpatient behavioral health stay; or
- \$10 if it is more than 7 days but within 30 days after an inpatient behavioral health stay.
- \$20 for seeing your doctor within 14 days after an inpatient hospital stay.

A few reminders about the CountyCare OTC Rewards Card:

- Keep your card! We will add more rewards as you earn them. Your card can be used at stores like: Dollar General, Family Dollar, Walmart and CVS (not in Target stores). Your card won't buy alcoholic or tobacco products.

- Get the Free Smartphone App – You can keep up with the CountyCare Rewards Program on your phone. Download the OTC Card Network app. It works for Apple or Android. Use the app to:
 - Check your balance
 - Locate stores
 - View eligible items and discounts
- Reward funds will expire six months from the date they are added to your card if they are not used.

Additional CountyCare Benefits

Free LASIK Eye Surgery

Members between the ages of 21 and 50* who meet the qualifications can receive LASIK eye surgery at no cost to them. For more information go to our website or call Member Services at 312-864-8200.

*Members over 50 years old with no indication of cataracts, and who meet the health criteria, may be eligible for LASIK surgery and should schedule a general eye exam with an in-network doctor to complete the LASIK Evaluation Form.

Free Diapers

We will mail you a coupon for a FREE Jumbo Pack of diapers each month when your baby, up to 2 years old, is on schedule for shots.



Free Sleep Safe Kit

Pregnant members can call Member Services and request a Sleep Safe Kit. Once they have completed at least 4 prenatal visits and returned the signed waiver form, CountyCare will ship the free Sleep Safe Kit to their home. The kit includes:

- Pack 'n Play with fitted sheet
- SleepSac
- Baby Sleep board book
- Pacifier

Free Car Seat

Children up to 8 years old who are CountyCare members are eligible for a free car seat. Parents can call Member Services to request the seat and it will be shipped to the address that is provided. Pregnant women are encouraged to call a month before their due date so the seat arrives in time for the baby's birth.

Book Club for Kids

Members age 3 through 16 can sign up for our annual book club. CountyCare will mail kids a new book every three months. Kids ages 5 through 16 will receive a \$10 Target gift card along with their book.

Free Home Pregnancy Test

Female members of child bearing age can call Member Services and request up to one test per month. Money will be added to their OTC card so they can purchase a test or it will be mailed to the address they provide.

Weight Watchers Vouchers

CountyCare members get free vouchers for Weight Watchers meetings in your neighborhood. Call Member Services to request and we will mail them to you.

Free Cell Phone

CountyCare members are eligible for a free cell phone (one per household) through SafeLink. The program provides free minutes for health-related phone calls to CountyCare.

If you have questions about our extra benefits, please call CountyCare Member Services at 312-864-8200 / 855-444-1661 / 711 (TDD/TTY). You can reach us Monday through Friday from 8:00 AM to 6:00 PM, Saturday 9:00 AM to 1:00 PM or visit our website for more information.

COVERED HOME AND COMMUNITY BASED SERVICES (HCBS OR “WAIVER SERVICES”)

CountyCare operates five (5) HCBS Waiver Programs through the Illinois Department of Health Care and Family Services for individuals who qualify.

A waiver program provides services that allow individuals to remain in their own homes or live in a community setting, instead of living in an institution or a nursing facility. These HCBS waiver services are available in addition to medical and behavioral health benefits. The five (5) HCBS Waiver Programs currently operated by CountyCare include:

WAIVERS

Aging Waiver

For people 60 years of age and older and at risk of nursing facility placement.

Persons with Disabilities Waiver

For people that have a physical disability, that are between the ages of 18-59 and at risk of nursing facility placement.

HIV/AIDS Waiver

For people of any age that have been diagnosed with HIV or AIDS and are at risk of nursing facility placement.

Persons with Brain Injury Waiver

For people of any age with an injury to the brain who are at risk of nursing facility placement.

Supportive Living Facilities Waiver

For people 22-64 years of age with a physical disability or 65 years of age or older and would otherwise be in a nursing home.

CountyCare does not determine your eligibility for HCBS services. Eligibility is determined by the State of Illinois through the Determination of Need (DON) assessment tool. Following the assessment, an overall DON score is given, which will determine your eligibility.

The covered services within each waiver program are noted below.

Department on Aging (DoA)

Persons who are Elderly:

- Adult day service
- Adult day service transportation
- Homemaker
- Personal Emergency Response System (PERS)
- Automated Medication Dispenser Service (AMDS)

Division of Rehabilitation Services (DRS)

Persons with Disabilities or HIV/AIDS:

- Adult day service
- Adult day service transportation
- Environmental accessibility adaptations-home
- Home health aide
- Nursing intermittent
- Skilled nursing (RN and LPN)
- Occupational therapy
- Physical therapy
- Speech therapy
- Homemaker
- Home delivered meals
- Individual provider/personal assistant
- Personal Emergency Response System (PERS)
- Respite
- Specialized medical equipment and supplies

Division of Rehabilitation Services (DRS)

Persons with Brain Injury:

- Adult day service
- Adult day service transportation

- Environmental accessibility adaptations-home
- Supported employment
- Home health aide
- Nursing, intermittent
- Skilled nursing (RN and LPN)
- Occupational therapy
- Physical therapy
- Speech therapy
- Prevocational services
- Habilitation-day
- Homemaker
- Home delivered meals
- Individual provider/personal assistant
- Personal Emergency Response System (PERS)
- Respite
- Specialized medical equipment and supplies
- Behavioral services (M.A. and PH.D.)

Healthcare and Family Services (HFS)

Supportive Living Facility:

- Assisted living

LONG TERM CARE (LTC)

Long term care sometimes goes by different names such as nursing home, nursing facility, long term care facility or skilled nursing facility. These facilities have services that help both the medical and non-medical needs of residents who need assistance and support to care for themselves due to a chronic illness or disability. If you are living in a long term care facility, CountyCare has supports in place to ensure you are getting the care you need. If you are able, we have resources to assist in transitioning you back to living independently in the community.

Contact your care coordinator if you would like to talk about long term care or living in the community.

MANAGED LONG TERM SERVICES & SUPPORTS (MLTSS) COVERED SERVICES

MLTSS is a program for members who have full Medicaid and Medicare benefits, who live in a nursing facility or receive HCBS (Waiver Services).

MLTSS Covered Services include:

- Some mental health services
- Some alcohol and substance use services
- Non-emergency transportation services to appointments
- Long Term Care services in skilled and intermediate facilities
- All Home and Community Based Waiver Services like the ones listed above under 'Covered HCBS Services' if you qualify

DENTAL SERVICES

CountyCare provides your dental coverage. Dental cleanings can help prevent cavities and other problems with your teeth. You should visit your dentist regularly.

Dental Benefit for Members 20 years of age and younger

- CountyCare covers one dental exam and one cleaning every six months.
- CountyCare covers x-rays, sealants, fillings, oral surgery, crowns (caps), root canals, dentures and extractions (pulling teeth) for members 20 years old and younger.

Dental Benefit for Members 21 years of age and older

- CountyCare covers some routine and medically necessary dental services, including x-rays,

fillings, crowns, root canals (front teeth only), oral surgery, extractions, dentures and denture repairs for members 21 years of age and older.

- Pregnant women get regular checkups, cleanings and periodontal work (deep cleaning and tooth scaling).
- As an added benefit, CountyCare also covers regular exams and cleanings every six months for members 21 years of age and older.

All members are covered for emergency dental services.

If you have questions about specific services please call Member Services. In order to receive dental services, you must go to an in-network provider. You can find a CountyCare dental provider by going on our website www.countycare.com or by calling CountyCare Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

VISION SERVICES

CountyCare has a large network of vision providers. We offer exams to all of our members. You also have the choice between glasses or contact lenses.

You get:

- One eye exam from our network of optometrists and ophthalmologists every year.
- Your choice from our standard selection of frames; or you can choose a \$100 allowance toward the retail value of frames. If the frames cost more than \$100, you are responsible to pay for the difference in price. You are eligible for new glasses every two years.
- If certain prescription requirements are met, single vision and bifocal lenses for your glasses are fully covered.
- You can choose contact lenses instead of eye glasses, the fitting fee is fully covered and you get a \$100 allowance toward the cost of your contact lenses. If the cost of your contact lenses is above \$100, you are responsible to pay for the difference in price.

You must use an in-network vision provider. To find a vision provider, call CountyCare Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) or check online at www.countycare.com.

BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

If you have a life-threatening emergency, please call 911 or go to the nearest hospital emergency department.

CountyCare, through our large network of providers, offers behavioral health services to treat mental health and substance use disorders. Behavioral health services are available for children and adult CountyCare members. We want to help you stay healthy in mind as well as body. To access these services, please call Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY), select 4 then select 1 for behavioral health. You will have an option to transfer to a provider who can see you for your first appointment within seven days. Services are available at outpatient, inpatient and residential levels depending on the need of the member.

Our network of providers offer treatment for:

- Anxiety
- Bipolar disorder
- Depression
- Schizophrenia
- Substance use disorders (such as drug and/or alcohol use)
- Other mental or behavioral health conditions

Behavioral health services that are covered by CountyCare include but are not limited to:

- Medication Assisted Treatment for substance use disorder, like Methadone, Suboxone and Vivitrol
- Crisis stabilization services
- Medication management

- Mental health assessments
- Case management
- Individual, group, and family therapy
- Psychological testing
- Community support
- Partial hospitalization
- Inpatient psychiatric care
- Electroconvulsive Therapy (ECT)
- Withdrawal management
- Residential rehabilitation

If you need these services speak with your PCP, your care coordinator, or call us at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY). You can also go to our website and select a provider you wish to see. CountyCare will only pay for services provided by an in-network provider. To find a behavioral health provider, go to our website at www.countycare.com or call us. You can find out if your preferred provider is in-network and get more information about behavioral health services.

Mobile Crisis Response Services - CARES

CARES stands for Crisis and Referral Entry Services. CARES is a telephone response service that handles mental health crisis calls for children and families in Illinois. CountyCare members can use the 24-hour Crisis and Referral Entry Services (CARES) line to talk to a behavioral health professional. You can call if you or your child is a risk to themselves or others; having a mental health crisis; or if you would like a referral to services. Call the CARES line at 1-800-345-9049 (TTY: 1-773-523-4504).

FAMILY PLANNING SERVICES

CountyCare has a network of family planning providers where you can get family planning services. You can get services from any qualified family planning provider. S/he does not have to be a network provider. You do not need a referral from your PCP or permission from CountyCare to get these services.

CountyCare Covers:

- All contraceptive methods, including birth control devices and the fitting or insertion of the device (such as IUDs or implants).
- Over-the-counter and prescription emergency contraception.
- Permanent contraceptive methods, including vasectomies and tubal ligations.

PREGNANCY/ MATERNITY SERVICES

CountyCare Covers:

- Outpatient health care provider services, including prenatal and postpartum check-ups, laboratory screenings and ultrasound and care for problems or complications of pregnancy or childbirth.
- Inpatient hospital services in a participating hospital, out-of-hospital birth center care and out-of-network emergency labor and delivery services.
- Prenatal diagnostic procedures, including genetic testing, are covered if you have a high-risk pregnancy.

You may stay at the hospital for at least 48 hours after a normal vaginal delivery and at least 96 hours after a cesarean section delivery.

Sometimes mothers want to leave sooner. You can leave sooner if, after talking to you, your doctor approves your discharge and makes an outpatient appointment for you and the baby within 48 hours.

You can choose a certified nurse midwife to deliver your baby. You can look for a certified nurse midwife in the CountyCare Health Plan provider directory under "Specialty Provider." You do not need CountyCare's approval to see a certified nurse midwife.

Adding Your Baby to Your Case

One of the most important things you can do is to make sure your baby has health coverage. In the week after your baby is born, please call DHS at 1-800-843-6154 or log on to the Application for Benefits Eligibility (ABE) System at www.abe.illinois.gov.

[illinois.gov](http://www.illinois.gov). After you log on to ABE, go to Manage My Case to add your baby and choose to stay with CountyCare. You will receive a notification in the mail when your baby has been added. If you would like assistance with getting your baby enrolled, please reach out to your care coordinator who can walk you through the ABE process by contacting customer service at 312-864-8200.

BRIGHTER BEGINNINGS PROGRAM

Brighter Beginnings is a program to help expectant families and babies stay healthy during pregnancy and after the baby is born. For additional information about Brighter Beginnings, please visit the CountyCare website.

CountyCare Rewards for Moms and Babies:

- Prenatal Visits: You can earn \$10 on a CountyCare OTC Rewards Card for going to your prenatal visits. You will receive \$25 when you see your provider for a checkup 1-12 weeks after giving birth.
- Well-Baby Visits: Earn a \$50 reward when you bring your baby in for a checkup within one month of your baby's birth. Earn \$10 for the next five visits.
- Immunizations: Earn a \$10 reward for each of the first 10 immunizations your baby receives.

Members have six months from the date the reward is added to use the credit. After six months the reward will expire.

CountyCare Extra Benefits for Moms and Babies:

- Free car seat: CountyCare provides free car seats for members who are expecting and children up to 8 years old. Call Member Services at 312-864-8200 to request a car seat and it will be shipped to you.
- Sleep Safe Kit: Pregnant members can call Member Services and request a Sleep Safe Kit. Once you have attended at least 7 of your prenatal visits and signed and returned the waiver form, the kit will be delivered to your home. The kit includes a portable crib, a SleepSac, a Baby Sleep board book and a pacifier.

- Free breast pump: CountyCare covers double electric breast pumps. Talk to your provider about ordering a pump for you. You can pick it up or have it delivered to your home.
- Free diaper coupons: All families with a baby under 2 years old will receive a coupon in the mail once a month for a free pack of diapers. CountyCare will automatically mail the coupon when your baby's shots are up to date.

PHARMACY SERVICES

As a CountyCare member, your prescription drugs are provided at no cost to you when you get your prescriptions filled at an in-network pharmacy.

To get your medication you need a prescription from your provider. To fill or refill your prescriptions, take your prescription to one of our in-network pharmacies.

Our pharmacy network includes several national retail chains such as CVS, Kmart, Walgreens, Meijer, Osco, Target, and Walmart, as well as independent pharmacies. Make sure you have your CountyCare member ID card to show at the pharmacy.

You may also use the Cook County Health pharmacies if you see a Cook County Health provider. If your PCP is part of a community health center, you may be able to use their pharmacy to get your prescription.

You can see all of the medications we cover on our County Care Formulary. You can find the Formulary on our website at www.countycare.com under Member Services. If you do not have access to the internet, please call Member Services and we will mail you a paper copy. If you need a medication that does not appear on the Formulary, your doctor can ask CountyCare for a review.

If you are new to CountyCare, you can continue any medication that you are currently using for your first 90 days with us even if it is not a part of the CountyCare Formulary.

CountyCare also covers over-the-counter medications on our Formulary at no cost to you. You will need a prescription from your provider to have the over-the-counter drug covered.

TRANSPORTATION SERVICES

CountyCare can offer transportation to and from doctors' appointments. They will need to be for covered services. You can:

- Ask for passes (Ventra and PACE) 2 weeks before your appointment. Just call Member Services at 312-864-8200, 711 (TDD/TTY).
- Coordinate a ride through First Transit. You will need to do it at least 72 hours (3 days) before your appointment. Call First Transit Member Services at 630-403-3210/711 (TDD/TTY). Your care coordinator or case manager can also do this for you.

AMBULANCE TRANSPORTATION

Emergency Ambulance Coverage

Your coverage includes ambulance service for emergency care. If you are having a medical emergency, call 911.

Non-Emergent Ambulance Transportation Criteria

Effective January 1, 2022, scheduling of all ambulance trips that are not emergencies has changed to the Illinois Department of Healthcare and Family Services Fee-for-Service (HFS FFS) due to [Public Act 102-0661](#). CountyCare will no longer be scheduling these trips. First Transit Fee-for-Service (FFS) is the Department's prior approval vendor and is not a transportation broker.

If you need ambulance services that are not an emergency, you will need to:

- Call First Transit FFS directly at 877-725-0569 (Monday through Friday, 8 a.m. to 5 p.m. CST).
- First Transit FFS will initially verify your eligibility. They will ask some questions to see if you meet the criteria.
- If you are eligible, First Transit FFS will send you a list of ambulance providers for you to call and schedule your trip.
 - If you have problems scheduling a trip, you can call First Transit FFS again for help.

- If you are not eligible for an ambulance that is not an emergency, please contact First Transit FFS transportation at 630-403-3210 to make other plans.
- You will need to contact First Transit FFS again to finalize the trip.
- A Physician Certification Statement (PCS) form will be needed for all ambulance trips that are not emergencies.

Only non-emergencies ground ambulance transportation services will be moving from CountyCare to First Transit FFS. All other transportation requests (Air Ambulance, Medicar, Service Car, Taxi and Private Audio) will remain the same.

You can call CountyCare Member Services at 312-864-8200, 711 (TTY/TDD) with any questions. You can also contact the Bureau of Professional and Ancillary Services at 877-782-5565 for fee-for-service issues.

CARE COORDINATION

CountyCare has several programs to improve the health of our members. We do this through education and personal help from CountyCare staff. This is called care coordination. The goal of this service is to add to the quality of your care and give you the support to help you improve your health. You can find out who your care coordinator is by calling Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

Your CARE COORDINATOR will help you through:

- Contact with you, your caregiver and your health providers
- An assessment of your conditions
- Care planning by helping you set your short and long-term goals
- Coordination of services to provide necessary and efficient care

A CARE COORDINATOR is a resource person that:

- Answers your questions
- Shares their knowledge of the health care system
- Helps you consider your options and choices
- Helps with referrals for treatment at health care facilities
- Identifies covered benefits
- Helps plan your transition out of the hospital
- Helps connect you with community resources
- Visits you at a health care facility or where you live

The information obtained through our care coordination process is confidential. It is shared only when needed to help plan your care and to properly pay for your services.

POPULATION HEALTH MANAGEMENT PROGRAMS

Health Screening, Assessment and Care Plan

To do that, your **care coordinator or another member of our team** will call you to ask some basic questions about your health and safety. This is called a **"health screening."**

If you tell us you have some medical conditions or other concerns affecting your health, we may ask you more questions to find out what services we can suggest. This is called a **"health assessment."**

If you qualify for the care management program, you and your care coordinator will make a **"care plan."** The plan will list the services you want us to help with and things you want to do for yourself or your child.

Your care plan is an Individual Plan of Care (IPoC) and can include anything that will help: appointments with providers; education about medical conditions; access to sources of food, clothing, transportation, housing or job training; arrangements at your child's school; steps you want to take to improve your health or prepare for the future.

The information we get from you is confidential. We normally share it (on a need-to-know basis) with anyone who is helping you - for example, your doctor, your community agency, or your child's school - to make sure that everyone is clear about what they are supposed to do. You can always tell us not to share information with certain people if you wish.

You also can choose whether you want us to provide screening, assessment and care plan services. You can opt in or out at any time. At any time, you can request the following from a care coordinator:

- Information about wellness or health conditions
- Problem-solving support

Programs for People with Special Conditions

We may have programs to help people with specific medical, behavioral health or other conditions. If you have one of these conditions, we may call you to see if you wish to be in a program. You can choose whether or not to be in any program. You may also ask your care coordinator if you qualify for any programs.

Do-It-Yourself Health Screenings

Are you curious about your health?
Do you want to feel your best?

CountyCare offers [online tools](#) that you can use on your mobile phone or computer to learn more about your health habits.

Go to our [Health & Wellness page](#) and click on the tool that interests you and answer the questions. You will get a personalized list of steps you can take to improve your health.

You can answer the questions as often as you like or not at all. No health plan staff or people helping you will know what you answered.

But you can print a copy and show it to your health care provider if you see something you want to discuss.

If you have trouble using these tools, your care coordinator can help by telephone.

CARE MANAGEMENT MEMBER RIGHTS AND RESPONSIBILITIES

A member can agree to be enrolled in a care coordination program. During this program your care coordinator will work closely with you to support and help you improve your health.

Member Rights

CountyCare members have the right to:

1. Have information about CountyCare programs. Have information about CountyCare, our staff and their qualifications.
2. Choose not to participate in CountyCare programs or services.
3. Know the staff members responsible for your care management services. Know how to change your care manager.
4. Have CountyCare support when making health care decisions.
5. Know all the care management services that are available. Discuss these services with your provider.
6. Have your medical information kept safe. Know who has access to your information. Know how CountyCare keeps your information safe.
7. Be treated with respect and dignity by CountyCare's staff at all times.
8. Communicate a complaint to CountyCare. Know how to file a complaint. Know how long it takes to get an answer to your complaint.
9. Have information in a language or method you can understand.
10. Be understood. This includes if you have limited English, have a different culture, or a disability.
11. Receive a copy of your care plan (Individualized Plan of Care/IPoC).

You are able to use your rights without any action taken against you.

Member Responsibilities

CountyCare members have the responsibility to:

1. Follow the instructions and care plan (IPoC) agreed upon by you and your provider.
2. Treat your care manager and your care coordination support team with courtesy and respect at all times.
3. Give CountyCare the right information so we can give the services you need.
Let CountyCare and your treating provider know if you leave the CountyCare Care Management program.
4. Additional responsibilities apply to members in Home and Community Based Services. Please see that section of the manual for further information.

Disenrollment

A member may disenroll or "opt-out" from care management voluntarily and/or when their condition and circumstances improve. Please contact your care coordinator to assist with this process.

Care management or care coordination services may be discontinued for members who do not fulfill their responsibilities listed above.

Care Management Program Participation for HCBS Members – (M)LTSS

Members enrolled in Home and Community Based Services (HCBS) must participate in care management. Failure to participate in home visits and/or provide written consent or acknowledgement will imply non-participation in care management. HCBS Members must also adhere to the program rules around cooperation: being present in the home to receive the services, notifying the provider in advance of any

absences, allowing the provider to come into the home to provide the services, not interfering with the delivery of services, and must not threaten or act abusively. HCBS members who do not permit home visits, refuse care coordination, or fail to abide by an established memorandum of understanding (MOU) sometimes called a Care Management Agreement, will be referred to the respective state agency for review of waiver eligibility and initiation of case closure.

(M)LTSS Member Rights

A (M)LTSS HCBS member's consent must be documented, as well as their written acknowledgement of understanding their rights and responsibilities, which include:

- Education on their member rights at the time of service initiation, at the time of change in service and annually
- Being given the opportunity to participate in choosing the types of services being delivered and providers
- Right of members to have input and agreement on the care plan
- Right of the member to refuse treatment or services and the implications of such refusal relating to benefits eligibility and/or health outcomes
- Education on how and to whom to report abuse, neglect and exploitation at the time of the assessment and reassessment
- Use of end of life and advance care directives
- Right to receive notification and rationale when CC/CM services are changed or terminated
- Alternative approaches when the member and/or family are unable to fully participate in the assessment phase



QUALITY IMPROVEMENT PROGRAM

We want you to get excellent health care and customer service. We measure ourselves every year to see what is going well and what could be going better. We want people get preventive care and care for their conditions and to be treated with courtesy and respect.

You may receive surveys to help us find out:

- Are you getting the care you need?
- Are you learning how to take better care of yourself?
- Are you satisfied with the services you receive?

We also act on information you provide us, such as when you:

- Tell us a grievance about quality of care
- Tell us a complaint about service

If you would like more information about CountyCare's Quality Improvement (QI) Program, please call Members Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY).

Some of these programs include:

- Preventive care and care you need for your health condition
- Member satisfaction surveys on the health care and services you have received
- Investigating quality of care grievances
- A team to address your complaints and improve the quality of care

If you would like more information on CountyCare's QI Program, please call Members Services at 312-864- 8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

RECIPIENT RESTRICTION PROGRAM

The Lock-In Program, also known as the Recipient Restriction Program, was established by the Department of Healthcare and Family Services and CountyCare to make certain our members best use the services available to them. The goal of this program is to ensure that each member receives the right care at the right time for medical services and prescription drug therapy. This program assigns a member to a specific primary care physician or selected pharmacy. If selected for the program, each member will receive a written notice and is given the opportunity to appeal the Lock-In determination within 60 days of the Lock-In notice letter.

ADVANCE DIRECTIVES

You have a right to make decisions about your medical care. An advance directive is a written decision you make about your health care in the future in case you become too ill to make a decision at that time.

In Illinois there are four types of advance directives:

- **Health Care Power of Attorney** - This lets you pick someone to make your health care decisions if you are too sick to decide for yourself. You can print one from the CountyCare website: <http://www.countycare.com/Media/Default/Resources/AdvanceDirectivePowerOfAttorney.pdf>
- **Living Will** - This tells your doctor and other providers what type of care you want if you are terminally ill. Terminally ill means your condition will not get better.

- **Mental Health Preference** - This lets you decide if you want to receive some types of mental health treatment that might be able to help you
- **Do Not Resuscitate/Practitioner Orders for Life-Sustaining Treatment (DNR/POLST) order** - This tells your family, all your doctors, and other providers what you want to do in case your heart or breathing stops. It can also be used to write down your wishes for life-sustaining treatment.

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

You can state your medical care wishes in writing while you are healthy and able to choose. An advance directive is a written statement about how you want medical decisions made when you can no longer make them. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. It also must ask you if you have put your wishes in writing.

No one can make you complete an advance directive. You decide if you want to have an advance directive. Anyone 18 years of age or older who is of sound mind and can make his or her own decisions can have an advance directive. You do not need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

Talk to your provider to get an advance directive form. You can also call Member Services for an advance directive form.

The Illinois Department of Public Health's website also has helpful information regarding advanced directives. You can find those resources here:

<http://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>

GRIEVANCE & APPEALS

We want you to be satisfied with services you get from CountyCare and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item.

CountyCare takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. CountyCare has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

If the grievant is a customer of the Vocational Rehabilitation (VR) program, the grievant may have the right to the assistance of the DHS-ORS Client Assistance Program (CAP) in the preparation, presentation and representation of the matters to be heard.

These are examples of when you might want to file a grievance:

- Your provider or a CountyCare staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a CountyCare staff member was rude to you.
- Your provider or a CountyCare staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). You can also file your grievance in writing via mail or fax to:

CountyCare Health Plan

P.O. Box 21153

Eagan, MN 55121

Fax: 866-200-5031

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at 312-864- 8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative."

To appoint someone to represent you, either:

1. Send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information, or,
2. Fill out the Authorized Representative form. You may find this form on our website at http://www.countycare.com/Media/Default/pdf/2018/CountyCare_Authorized_Rep_Form_110218.pdf

CountyCare will send you an acknowledgment letter within 48 hours saying we received your grievance. CountyCare will try to resolve your grievance right away. If we cannot, we may contact you for more information. Within 90 days, you will receive a letter from CountyCare with our resolution.

Appeals

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

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services

You may not agree with a decision or an action made by CountyCare about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **60 calendar days** of the date on our Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **10 calendar days** from the date on our Adverse Benefit Determination letter. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

Here are two ways to file an appeal:

1. Call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). If you file an appeal over the phone, you must follow it with a written signed appeal request.
2. Mail or fax your written appeal request to:

CountyCare Health Plan

P.O. Box 21153

Eagan, MN 55121

Phone: 312-864-8200 / 855-444-1661
(toll-free) / 711 (TDD/TTY)

Fax: 866-200-5031

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

Can someone help you with the appeal process?

You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your primary care physician or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either:

1. Send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information, or,
2. Fill out the Authorized Representative form. You may find this form on our website at http://www.countycare.com/Media/Default/pdf/2018/CountyCare_Authorized_Rep_Form_110218.pdf

Appeal Process

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

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

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

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

If CountyCare's decision agrees with the Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If CountyCare's decision does not agree with the Adverse Benefit Determination, we will approve the services to start right away.

Things to keep in mind during the appeal process:

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

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process.

However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

CountyCare will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call CountyCare at 312- 864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY)

What happens next?

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

State Fair Hearing

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

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- Visit <https://abe.illinois.gov/abe/access/appeals> to set up an ABE Appeals Account and submit a State Fair Hearing Appeal online. This will allow you to track and manage your appeal online, viewing important dates and notices related to the State Fair Hearing and submitting documentation.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

**Illinois Department of Healthcare
and Family Services**
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-2005
Email: HFS.FairHearings@illinois.gov

Or you may call 855-418-4421 / TTY: 800-526-5812

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

**Illinois Department of Human
Services Bureau of Hearings**
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: (312) 793-8573
Email: DHS.HSPApeals@illinois.gov

State Fair Hearing Process

The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings Office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at <http://abe.illinois.gov/abe/access/appeals>, you can access all letters related to your State Fair Hearing process through your ABE Appeals Account. You can also upload documents and view appointments.

At least three business days before the hearing, you will receive information from CountyCare. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to CountyCare and the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you or your authorized representative do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your

appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

Within **30 calendar days** after the date on the CountyCare appeal Decision Notice, you may choose to ask for a review by someone outside of CountyCare. This is called an **external review**. The outside reviewer must meet the following requirements:

- Board certified provider with the same or like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your identity during the review

External Review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

Your letter must ask for an external review of that action and should be sent to:

CountyCare Health Plan

P.O. Box 21153

Eagan, MN 55121

Phone: 312-864-8200 / 855-444-1661

(toll-free) / 711 (TDD/TTY)

Fax: 866-200-5031

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have five business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five business days from the letter we send you to send any additional information about your request to the external reviewer.

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

Expedited External Review

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an **expedited external review**. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). To ask in writing, send us a letter at the address below. You can only ask one time for an external review about a specific action. Your letter must ask for an external review of that action.

CountyCare Health Plan

P.O. Box 21153

Eagan, MN 55121

What Happens Next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and CountyCare know what their decision is verbally. They will also follow up with a letter to you and/or your representative and CountyCare with the decision within 48 hours.

RIGHTS & RESPONSIBILITIES

As a CountyCare member we must honor your rights and cannot punish you when you exercise your rights.

Member Rights:

- Be treated with respect and dignity at all times.
- Have your personal health information and medical records kept private except where allowed by law.
- Be protected from discrimination.
- Be free from any form of restraint or seclusion used as a way to force, control, and ease of reprisal or retaliation.
- Receive information, including the member handbook from CountyCare in other languages such as audio, large print or Braille.
- Have use of an interpreter when needed.

- Have a candid discussion with your provider about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information on available treatment options and alternatives. This includes the right to ask for a second opinion. Providers must explain your treatment options in a way you understand.
- Receive information necessary to be involved in making decisions about your health care treatment and choices.
- Refuse treatment and be told what may happen to your health if you do.
- Receive a copy of your medical records and in some cases request that they be amended or corrected.
- Choose your own primary care provider (PCP) from CountyCare. You can change your PCP at any time.
- File a complaint (sometimes called a grievance), or appeal about CountyCare or the care you received without fear of mistreatment or backlash of any kind.
- Appeal a decision made by CountyCare on the phone or in writing.
- Have an interpreter during any complaint or appeal process.
- Request and receive in a reasonable amount of time, information about CountyCare Health Plan, and its providers, services and policies.
- Receive information about CountyCare Member Rights and Responsibilities. You also have the right to suggest changes in this policy.
- Receive health care services in ways that comply with federal and state law. CountyCare must make covered services accessible to you. Services must be available 24 hours a day, seven days a week.

Member Responsibilities:

- Treat your doctor and the office staff with courtesy and respect.
- Carry your CountyCare ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.
- Keep your appointments and be on time for them.
- If you cannot keep your appointments cancel them in advance.
- Provide as much information as possible so that CountyCare and their providers can give you the best care possible.
- Know your health problems and take part in making decisions about your treatment goals as much as possible.
- Follow the instructions and treatment plan agreed upon by you and your doctor.
- Tell CountyCare and your care coordinator if your address or phone number changes.
- Tell CountyCare and your care coordinator if you have other insurance and follow those guidelines.
- Read your member handbook so you know what services are covered and if there are any special rules.

Provider Qualifications and Doctor Incentives

You have the right to information about our providers. This includes the provider's:

- Education
- Board certification
- Recertification

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of referrals and other services you might need. To get this information, call us.

FRAUD, WASTE AND ABUSE

Reporting Fraud, Waste and Abuse (FWA) is the responsibility of everyone.

Let us know if you think a doctor, dentist, pharmacist at a drugstore, or any other health care provider or even a person getting benefits is doing something wrong.

Doing something wrong could be fraud, waste, or abuse, which is against the law.

- Fraud is when someone receives benefits or payments they are not entitled to.
- Waste is when someone overuses or misuses Medicaid program services, resources, or materials that results in unnecessary costs.
- Abuse is when someone causes financial harm or injury.

Fraud, waste and abuse are all incidents that need to be reported.

Tell us if you think someone is:

- Getting paid for services that were not given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Misusing their plan benefits.
- Letting someone use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources they have to get benefits.

CountyCare will send you letters from time to time to ask you to confirm that you received medical services. Please review and answer these letters. This helps us prevent FWA. There are many ways to report FWA.

What Can I Do?

If you believe a health care provider or person getting benefits is doing something wrong, you should report this right away. All information will be kept private.

There are many ways to report Fraud, Waste and Abuse:

CountyCare Fraud, Waste and Abuse Hotline	844-509-4669
CountyCare Member Services	312-864-8200 855-444-1661 711 (TDD/TTY)
HFS Medicaid/Welfare Fraud Hotline	844-453-7283 844-ILFRAUD
DHS Office of the Inspector General	800-368-1463
IL Department on Aging	866-800-1409 888-206-1327 (TTY)
Senior Helpline	800-252-8966

HEALTH, SAFETY, WELFARE, REPORTING AND FOLLOW-UP OF INCIDENTS

Incidents regarding member health, safety and welfare are defined by Illinois State law. They involve actions that may risk the health, safety, and well-being of vulnerable adults by causing harm or creating a serious risk of harm to a person by their caregiver or other trusted person, whether or not harm is intentional.

Types of Incidents include:

Physical abuse – the willful infliction of physical pain or injury, or the willful deprivation of services necessary to the physical safety of an individual

Emotional abuse – an act that inflicts emotional harm, invokes fear or shame or otherwise negatively impacts the mental health or safety of an individual

Neglect – the failure of an agency, facility, employee, or caregiver to provide important services needed to maintain the physical and or mental health of a vulnerable adult

Financial abuse – the misuse or taking of the vulnerable adult's property or resource using undue influence, breach of a fiduciary relationship, deception, harassment, criminal coercion, theft, or other unlawful or improper means

Incident Reporting Requirements

Incidents involving member abuse, neglect and financial abuse must be reported to authorities, as required by state law.

How to Report an Incident

Incidents related to CountyCare members can be reported to CountyCare by phone, email, or fax.

Call Provider Services at **312-864-8200/855-444-1661 / 711 TTD/TTY**

Email: countycarequalityofcare@cookcountyhhs.org

Fax: 312-637-8312

You may also report Incidents to the right state agency, as follows:

- **For members 18-59 with a disability or 60 and older living in the community:**
 - *Illinois Department on Aging-Adult Protective Services*
 - Hotline Telephone Number: **866-800-1409 (voice) TTY: 888-206-1327**
- **For members under the age of 18 years old:**
 - *Illinois Department of Children & Family Services (DCFS) Hotline*
 - Telephone Number: **800-252-2873 (voice) TTY: 800-358-5117. For non-DCFS membership.**
- **For members in Nursing Facilities:**
 - *Department of Public Health Nursing Home Complaint*
 - Hotline Telephone Number: **800-252-4343**
- **For members 18-59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified or funded programs:**
 - *Illinois Department of Human Services Office of the Inspector*
 - General Telephone Number: **800-368-1463 (voice and TTY)**
- **For members in Supportive Living Facilities:**
 - *Department of Healthcare and Family Services SLF*
 - Complaint Hotline Telephone Number: **800-226-0768**

If you or a family member witness, told of, or suspect an incident of abuse, neglect, financial abuse or any other event that may place the member at risk or the member services at risk it is important to report the allegation immediately. Below are a few examples:

Physical abuse signs to look for:

- Punching, hitting, beating
- Slapping, smacking
- Pushing, shoving, shaking
- Pinching, cutting, slicing
- Improperly physically restraining

Sexual abuse signs to look for:

- Rape
- Date rape
- Attempted rape
- Inappropriate touching
- Sexual assault or battery
- Coerced nudity
- Sexually explicit content

Emotional abuse signs to look for:

- Name calling
- Yelling, bullying
- Ridicule, insults
- Threats
- Coercion, manipulation

Neglect signs to look for:

- Injury that has not been cared for properly
- Dehydration or malnutrition without illness-related cause
- Poor coloration, sunken eyes or cheeks
- Soiled clothing or bed
- Lack of necessities such as food, water, or utilities
- Same clothing all of the time
- Fleas, lice on individual
- Unkempt, dirty
- Hair matted, tangled or uncombed

Financial abuse signs to look for:

- Accessing another individual's funds without consent
- Changing ownership of assets
- Forged signature for financial transactions
- Changing legal documents, such as wills
- Using someone else's money for personal reasons



DEFINITIONS

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

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

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

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

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

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

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

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

Home Health Care means health care services a person receives at home.

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

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

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

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

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

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

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

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

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

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

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

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

DISCLAIMERS

Nondiscrimination Statement

Discrimination is against the law. CountyCare complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CountyCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CountyCare:

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

If you need these services, please contact **CountyCare Member Services** at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

If you believe that CountyCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CountyCare Health Plan

ATTN: Compliance

300 S Riverside Plaza, 4th Floor

Chicago, Illinois 60606

Fax: (312) 548-9940

You can file a grievance in person or by mail, fax, or via our website. If you need help filing a grievance, the CountyCare Grievance & Appeals Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue,

SW Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at

<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

English:

ATTENTION: If you speak ENGLISH, language assistance services, free of charge, are available to you. Call 312-864-8200 / 855-444-1661 (toll-free) / 711 (TTY).

Spanish:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 312-864-8200 / 855-444-1661 / 711 (TTY).



Polish:

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 312-864-8200 / 855-444-1661 / 711 (TTY).

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 312-864-8200 / 855-444-1661 / 711。

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 312-864-8200 / 855-444-1661 / 711. 번으로 전화해 주십시오.

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 312-864-8200 / 855-444-1661 / 711.

Arabic:

تدعاسملا تامدخ نإف، ةغلل ركذا تدرحتت تنك اذا: ةظوحلم 312 مقرب لصتا. ناجملاب كل رفاوتت ةيوعغلل 864-8200 / 855-444-1661 / 711 (مصلا فتاه مقر) 312-864-8200 / 855-444-1661 / 711). مكلبل او

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 312-864-8200 / 855-444-1661 (телетайп: 711).

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 312-864-8200 / 855-444-1661 (TTY: 711).

Urdu

نابز وک پآ وت، سکی ےتلوب ودرآ پآ رگا: رادربخ - سکی بایتسد سکی تدم تامدخ یک ددم یک لک 312-864-8200 / 855-444-1661 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 312-864-8200 / 855-444-1661 (TTY: 1-711).

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 312-864-8200 / 855-444-1661 (TTY: 711).

Hindi

312-864-8200 / 855-444-1661 (TTY: 711) पर कॉल करें।

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 312-864-8200 / 855-444-1661 (ATS : 711).

Greek

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 312-864-8200 / 855-444-1661 (TTY: 711).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 312-864-8200 / 855-444-1661 (TTY: 711).

COUNTYCARE NOTICE OF PRIVACY PRACTICES

This notice tells you how your health information may be used and shared by your health plan. It also describes how you can access your own health information. Please review it carefully.

What Is This Document?

This document, called a Notice of Privacy Practices, tells you how CountyCare may use and share your health information. We must keep your health information private and secure. We will let you know if a breach occurs that affects the privacy or security of your information. The notice also explains how you can get access to your own health information.

What Is Health Information?

The words "health information" mean any information that identifies you. Examples include your name, date of birth, details about health care you received or amounts paid for your care.

Why Are You Giving This To Me?

We are required by law to give you this notice. We must follow the practices in this notice. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can share your information, you may change your mind at any time. Let us know in writing if you change your mind.

Who Follows This Notice?

All employees, contractors, consultants, vendors, volunteers, and other health care professionals and organizations who work with CountyCare follow this notice.

How We Can Use And Share Your Health Information

To Manage Your Health Care Treatment.

We will use and share your health information to help with your health care.

For Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange for additional services.

For Example: We may share your health information with a service agency that arranges health care supportive housing services.

For Health Care Operations. We will use and share your health information to help us do our job. We may contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

For Example: We use your health information to develop better services for you or to make sure you are receiving good services.

For Example: We submit data related to your health information to the state to show we are following our contract.

To Pay for your Health Services. We will use and share your health information as we pay for your health services.

For Example: We share information about you with your prescription plan to coordinate payment for your prescriptions.

To Administer Your Plan. We may share your health information with other businesses for plan administration.

For Example: We share your information with a transportation company to make sure you get to your important appointment.

With Business Associates. We may share your health information with another company, called a business associate, which we hire to provide a service to us or on our behalf. We will only share your information if the business associate has agreed in writing to keep health information private and secure.

Ways We Can Use Or Share Your Health Information With Your Permission

You can choose how we share your information in the situations described below. Tell us what you want us to do and we will follow your instructions. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest.

With Individuals Involved in Payment for Your Care. We may share health information about you with your family members, friends or other people who are involved in your health care or who help pay for it. You have the right to ask that we not share your information with certain people, but you must let us know.

To Share Information About Health-Related Benefits, Services and Treatment Alternatives.

We may tell you about health services, products, possible treatments or alternatives available to you. We may not sell your health information without your written permission.

Sensitive Information. Some types of medical information are very sensitive. The law may require that we obtain your written permission to share this information. Sensitive medical information may include genetic testing, HIV/AIDS testing, diagnosis or treatment, mental health, alcohol and substance use, sexual assault or in vitro fertilization. Your permission is also required for the use and sharing of psychotherapy notes.

Use of Your Information for Our Marketing.

We may not use or disclose your health information for marketing purposes unless we have your written permission.

Sale of Your Information. We may not sell your health information unless we have your written permission.

How We Must Share Your Health Information

We also have to share your information in situations that help contribute to the public good or safety. We have to meet many conditions in the law before we can share your information for these purposes.

Research. We can use or share your information for health research.

Public Health and Safety. We may share your health information for public health and safety reasons.

For example:

- To prevent or control disease;
- To help report information about bad products;
- To report adverse reactions to medications;
- To let you know that you may have been exposed to a disease or may be at risk for getting or spreading a disease or condition; or
- To your employer in certain limited instances.

Abuse and Neglect. We may have to share your information to report suspected abuse, neglect or domestic violence to state and federal agencies. You will likely be told that we are sharing this information with these agencies.

For Disaster Relief. We may share your health information in a disaster relief situation.

Prevent a Serious Threat to Safety. We may use and share your medical information to prevent or reduce a serious threat to your health and safety or the health and safety of others.

Comply with the Law. We must share health information about you when we are required to do so by federal or state laws.

As a Part of Legal Proceedings. We can share health information about you in response to a court order or a subpoena. We will only share the information stated in the order. If we receive any other legal requests, we may share your health information if we are told that you know about it and do not object to the release.

With Law Enforcement. We must share health information about you when we are required to do so by law or by the court process, including for the following:

- To identify or locate a suspect, fugitive, material witness or missing person
- To obtain information about an actual or suspected victim of a crime

We may also share information with law enforcement if we believe a death was the result of a crime or to report crimes on our property or in an emergency.

During an Investigation. We will share your information with the Secretary of the Department of Health and Human Services if they ask for it as part of an investigation of a privacy violation.

Special Governmental Functions. We may share your health information with:

- Authorized federal officials
- Military
- For intelligence, counter-intelligence and other national security activities
- To protect the president

Coroners, Medical Examiners and Funeral Directors. We may share health information with a coroner or medical examiner to identify a dead person or find the cause of death. We also may share health information with funeral directors if they need it to do their job.

Health Oversight Activities. Certain health agencies are in charge of overseeing health care systems and government programs or to make sure that civil rights laws are being followed. We may share your information with these agencies for these purposes.

Organ and Tissue Donation. If you are an organ donor, we may release health information to the organizations in charge of getting, transporting or transplanting an organ, eye or tissue.

Workers Compensation. We may share your health information with agencies or individuals to follow workers compensation laws or other similar programs.

Your Rights Regarding Your Health Information

You Have a Right to Request Restrictions. You have the right to ask us to limit the ways we use and share your health information for treatment, payment, and health care operations. We do not have to agree if it would affect your care.

You must submit your request in writing and it must be signed and dated. You should describe the information you want limited and tell us who should not receive this information. You must submit your written request to the Office of Corporate Compliance, 1950 W. Polk, Suite 9217, Chicago, IL 60612. We will tell you if we agree with your request or not. If we do agree, we will follow your request unless the information is needed to treat you in an emergency.

You Have a Right Get a Copy of Health and Claims Records. You have the right to read or get a copy of your health and claims records and other health information we have about you.

To see and obtain copies of your information you must complete your request in writing. We will give you a copy or a summary of your health and claims record within 30 days of your request. If you request a copy of your health and claims record, we may charge a reasonable, cost-based fee for the costs of copying, mailing or other expenses associated with your request.

You Have a Right to Request Changes. You may ask us to change your health information or payment record if you think it is incorrect or incomplete. You must send us a written request and you must provide the reason why you want the change. We are not required to agree to make the change. If we do not agree to the requested change, we will tell you why in writing within 60 days. You may then send another request disagreeing with us. It will be attached to the information you wanted changed or corrected.

You Have a Right to Request Confidential Communication. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will consider all reasonable requests. We must agree if you tell us you would be in danger if we do not follow your request.

You Have a Right to an Accounting of Disclosures. You have the right to make a written request for a list of the times we've shared your health information in the past six years. The list will have who we shared it with, the date it was shared and why. We will include all the disclosures except for those about treatment, payment, and health care operations and any disclosure you asked us to make. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months. Your written request must designate a time period.

You Have a Right to a Paper Copy of This Notice. You have the right to ask for a paper copy of this notice at any time. We will provide you with a paper copy promptly.



You Have a Right to Choose Someone to Act For You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

HIV Outreach Efforts

CountyCare 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.

Changes To This Notice

We may change our privacy policies, procedures, and this Notice at any time, and the changes will apply to all information we have about you. If we change this Notice, the new Notice will be posted on our website and we will mail a copy to you.

What If I Need To Report A Problem

If you are unhappy and report a problem we will not use your complaint against you.

If you believe CountyCare has violated your privacy rights in this Notice, you may file a complaint with CountyCare or with the Office for Civil Rights, U.S. Department of Health and Human Services.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:

U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201

You can also call 1-877-696-6775 or you may visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

You can contact the CountyCare Compliance and Privacy Officer to discuss any concern you have using the information below:

Office of Corporate Compliance
Cook County Health
1950 West Polk
Chicago, IL 60612
Telephone: 1-877-476-1873



YOUR CARE COORDINATOR

You can contact your care coordinator at 312-864-8200 / 855-444-1661 (toll-free), Monday through Friday, 8:00 AM-6:00 PM and Saturday, 9:00 AM-1:00 PM (Central Time). If you are hearing impaired, call our TDD/TTY line at 711.

It's important you keep in contact with your care coordinator. He or she will help you with services. Make sure to write down the name and phone number of your care coordinator.

**My CountyCare
Care Coordinator:** _____

Phone: _____



THANK YOU FOR CHOOSING
COUNTYCARE

