CountyCare
A MEDICAID HEALTH PLAN

HealthChoice Illinois

Member Handbook

**MEMBER SERVICES: 312-864-8200 /
855-444-1661 (TOLL-FREE) / 711 (TTY/TDD)**

Welcome to CountyCare

We are happy to have you as a member of CountyCare. We are committed to your health, well-being and getting you the health care that 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 to answer your questions at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY), Monday through Friday from 8 a.m. to 6 p.m.; and Saturday 9 a.m. to 1 p.m. (Central Time). 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. **It is staffed with nurses who can assist you in any language that you may need.** Our main goal is to make sure you receive high-quality health care.

This handbook is for CountyCare members and prospective members. It 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
- How to contact CountyCare for help

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

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

Important Phone Numbers & Contacts

CountyCare's normal business hours of operation are
Monday–Friday: 8 a.m. to 6 p.m. (Central Time)
Saturday: 9 a.m. to 1 p.m. (Central Time)

Emergency	9-1-1
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
Transportation	312-864-8200
Dental Benefits	312-864-8200
Vision Benefits	312-864-8200
Pharmacy Benefits	312-864-8200
Crisis and Referral Entry Services (CARES)	800-345-9049
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 (llamada sin cargos) / 711 (TTY).

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.。

After Hours & Holidays

When you need medical advice, you should first call your CountyCare doctor because they have access to your medical records and can give you personalized advice. If you cannot reach your doctor, 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). Nurses can assist you in any language 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 arrange 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.

Free Language Help

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

If your doctor does not speak your language or no one at their office can talk with you in a way you 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 or 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 (llamada sin cargos) / 711 (TDD/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.。

Other

This member handbook is available in hard copy and other languages and formats. 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-mails, texts or phone calls reminding you of needed exams. Text messages will come from the number 84908. If you are not getting our text messages, you can sign up to receive them at www.countycare.com/texts. You can tell your care coordinator or Member Services how you prefer to be contacted.

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

It is important to keep CountyCare and the Illinois Department of Human Services (DHS) 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
- Covered services
- Current news
- Member self-service features
- Online form submissions
- Health information
- Information on CountyCare programs and services

Our website address is: www.countycare.com. If you need help using our website or provider search tool because of a language need or disability, call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY)

CountyCare's Secure Member Portal

CountyCare has a secure member portal where you can:

- Change your primary care provider (PCP)
- Print a temporary ID card
- Send/receive secure messages to/from CountyCare through our secure messaging system
- Get personalized health information

To sign up for our secure member portal, go to www.countycare.com and click on the Member Portal. From there 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

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
855-444-1661 (toll-free)
711 (TDD/TTY)

Hours of Operation: Monday through Friday: 8 a.m. to 6 p.m. Central Time
Saturday: 9 a.m. to 1 p.m. Central Time

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

- Your benefits, including all the extra member rewards that CountyCare offers
- How to receive health care services
- How to update your contact information
- How to request a new member ID card
- How to select or change your primary care provider (PCP)
- Authorizations needed for any health care services
- How to contact our Nurse Advice Line
- How to receive emergency services or 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

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 by calling 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). 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. During this call, we may also ask about your race, ethnicity, preferred language, sexual orientation or gender identity. Sharing this information is your choice. We only use it to help make sure you can get the health care services you need. The representative will also answer your questions and ask you to complete a health-risk screening.

New Enrollee Transition of Care

If you are new to CountyCare and are 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 enrolled as a State of Illinois Medicaid provider 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 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

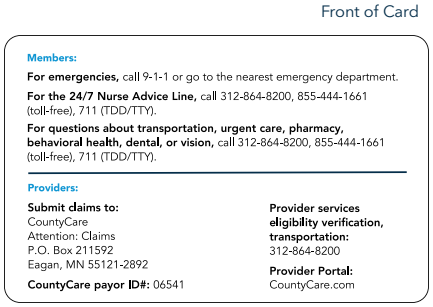
Your member ID card is in your welcome packet. Please check your ID card to make sure the information is correct. If your member ID card is not in your welcome packet, please call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Always carry your CountyCare ID card with you. Show it every time you see the doctor or pick up medication. 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.

Updating Your Address and Phone Number

It is very important to tell CountyCare, your care coordinator and the Illinois Department of Healthcare and Family Services (HFS) if your address or phone number changes. Please call CountyCare and give us your updated information. We can be reached at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY). You can reach HFS at 877-805-5312.

Front of Card



Back of Card

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, and it is included in the open enrollment letter. You will have until the date listed on your open enrollment letter to change health plans. You can switch plans by calling CES at 877-912-8880 or by visiting 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 have ended, whether you switched plans or not, you will be locked into your health plan for 12 months.

If you have questions regarding your enrollment or disenrollment with CountyCare, please contact CES at 877-912-8880.

Redetermination: Keeping Your Benefits

Redetermination is the annual process of making sure you are still eligible for Medicaid. You will receive forms in the mail from the State of Illinois at least 30 days before your redetermination date. Some members' Medicaid will be automatically renewed and they do not have to respond. The form they receive will say their coverage will be continued. Others will be required to respond. The forms that need to be completed will say "Medical Benefits: Time to Renew Notice." Members who receive these forms must complete them by the due date listed on the paperwork or they may lose their Medicaid coverage.

It's important to keep your address current with the State of Illinois to make sure you receive your renewal paperwork. If you move or have a new mailing address, call 877-805-5312 to update your contact information.

If you have questions or need help with your redetermination, you can call CountyCare's redetermination hotline at 312-864-REDE (7333).

Beware of scams. Illinois will never ask you for money to renew or apply for Medicaid. Report scams to the Medicaid fraud hotline at 1-844-453-7283/ 1-844-ILFRAUD.

What Happens If I Lose My Coverage?

If you miss your redetermination due date and lose your Medicaid coverage, you have up to 90 days to submit the forms. Once the State of Illinois has processed your redetermination, your Medicaid coverage will be reinstated if you are found to still be eligible, and you should be reenrolled.

Member Satisfaction Surveys

Your satisfaction with CountyCare is very important to us. You may receive a survey in the mail or by telephone asking 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 improve the services we provide.

Enrollee Advisory Committee

CountyCare invites our members to meet with us in person to share their opinions. 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 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 primary care provider (PCP) first. Your PCP will help manage all your health services. If you think you need to see a specialist or another provider, discuss this 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.

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, and they can schedule a new appointment for you. If you need help scheduling an appointment, call Member Services at 312-864-8200 /855-444-1661 (toll-free) / 711 (TDD/ TTY).

APPOINTMENT TYPE	ACCESS STANDARD
Routine visit	Within five weeks
Non-urgent visit	Within three weeks
Urgent-care visit	Within 24 hours
Emergency visit	Immediately, 24 hours a day, seven days a week and without prior authorization
Initial prenatal care visit	First Trimester: two weeks Second Trimester: one week Third Trimester: three days
After-hours coverage	24 hours per day, seven days per week
Office wait times	Within one hour of scheduled appointment

PCP After Hours

PCPs have 24-hour answering services or a telephone recording. They will tell you how to receive care after regular office hours.

If you have a medical problem or question and cannot reach your PCP during regular 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.

Time/Distance to Care

CountyCare members have access to 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 provider within their area. A member may choose to travel beyond the distance standards when selecting a PCP or specialty care provider.

Homebound Members

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

Provider Network

A "provider network" is the doctors, specialists, clinics and hospitals that health plans work with to provide health care to members. CountyCare has a large network of providers to choose from. You can see which providers are in our network by going to www.countycare.com and clicking on "Find a Provider." The provider directory displays each provider's name, address, telephone number, professional qualifications, specialty, education, board certification status, and languages spoken. You can call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TTD/TTY) for help finding a provider or to request a printed copy of the provider directory.

Primary Care Provider (PCP)

Every CountyCare member has a primary care provider (PCP). You should see your PCP for all routine care and screenings. We ask that you contact 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 you need help finding or changing your PCP, please contact Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

If needed, a specialist can also be assigned as your PCP. However, they will need to agree to provide you with that level of care, and CountyCare must also approve it. Please contact Member Services if you wish to request your specialist to be 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.

Women's Health Care Provider (WHCP)

You have the right to select a women's health care provider (WHCP). A WHCP is a doctor, advanced practice nurse (APN), physician assistant (PA), doula or midwife licensed and certified to practice obstetrics (OB), gynecology (GYN) or family practice.

You can choose a WHCP as your primary care provider, or choose a WHCP in addition to your PCP. You can go to any participating WHCP for routine preventive

OB/GYN care without approval from CountyCare or a referral from your primary care provider (PCP).

How To Change PCPs

You can find your primary care provider (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). We can help you find a PCP who meets your cultural, language or gender preferences or communication needs.

You can also log into our secure member portal to change your PCP online or fill out the PCP Change Request Form that is available on our website at www.countycare.com on the Resources page under "policies, procedures & forms".

A PCP change request will take effect on the first day of the following month. For example, change requests received Jan. 1-31 are effective on Feb. 1.

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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
- ☐ PCP already sees family member
- ☐ Member preference
- ☐ Member moved
- ☐ PCP hours didn't fit member's needs
- ☐ Quality of care
- ☐ Provider location
- ☐ 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
- ☐ 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, mail it to CountyCare Health Plan, P.O. Box 21153 Eagan, MN 55121, or email it to CountyCareCustomerService@evolent.com. 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, 8:30 a.m.-8 p.m., and Saturday, 9 a.m.-1 p.m., at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

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HealthChoice Illinois

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 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 a specific health condition. Examples of a specialist are a cardiologist (heart health) or orthopedist (bones and joints). If your primary care provider (PCP) thinks you need a specialist, they will work with you to choose one. 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, they need 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).

Urgent/Immediate Care Facilities

CountyCare has over 150 urgent/immediate care facilities in network for our members when you need prompt attention, but your condition is not life threatening.

Immediate care is different than emergency care. Some examples of immediate care include:

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

To find the urgent care location closest to you, go to www.countycare.com and click on "Find a Provider". You should ONLY go to the hospital emergency department for life-threatening situations or when your primary care provider (PCP) or any licensed health care provider advises you to go there.

Call your PCP or our 24-hour Nurse Advice Line at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY), and they will help you decide where to get care. If you need help finding a PCP or have questions, call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 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 911 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.
- If no 911 service is in the area, call an ambulance.
- Prior authorization and referrals are not needed. As soon as your condition is stable, you should call your primary care provider (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, visit www.countycare.com or 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 primary care provider (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 that 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 primary care provider (PCP) 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 at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD TTY).

- 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
- 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 the payment of any service you get outside of 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 can find a list of in-network providers and hospitals by using the Find a Provider search tool at www.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 exceptions are for emergency treatment, 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 for adults and children.

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 two weeks, one month, two months, four months, six months, nine months
Checkup	Ages 1-3	12 months, 15 months, 18 months, 24 months-30 months
Checkup	Ages 3-6	Annually
Checkup	Ages 6-21	Every year at minimum or more often if medically necessary
Checkup	Ages 22-65	Within the first year of enrollment and annually thereafter or as indicated by need and clinical care guidelines
Checkup	Over age 65	Annually
Clinical Breast Exam	Ages 20-40	Every one to three years
Clinical Breast Exam	Over age 40	Annually

Preventive Care for Women

EXAM	AGE	FREQUENCY
Pelvic Exam	Under age 39	Every three years
Pelvic Exam	Ages 40 & over	Annually or as directed by your doctor
Pap test	Ages 21 & over	Every three years (frequency depends on risk factors; ask your doctor)
Mammogram	Ages 40-49	Consult with your doctor
Mammogram	Ages 50-74	Annually

Additional Preventive Care

FEMALES

AGE	RECOMMENDED PREVENTIVE SERVICES
21-26	Flu vaccine (annually) Cervical cancer screening Human papillomavirus (HPV) vaccine All sexually transmitted infections testing Tetanus-diphtheria booster (should receive every 10 years)
27-49	Flu vaccine (annually) Cervical cancer screening Cholesterol testing (begin at age 35 and at five-year intervals thereafter) Type 2 diabetes screening (begin at age 45 and every three years after) Tetanus-diphtheria booster (should receive every 10 years)
50+	Flu vaccine (annually) Cholesterol testing (at five-year intervals) Cervical cancer screening Colorectal cancer screening (begin at age 50) Shingles (zoster recombinant) vaccine (two doses starting at age 50) Tetanus-diphtheria booster (should receive every 10 years) Pneumonia vaccine

MALES

AGE	RECOMMENDED PREVENTIVE SERVICES
21-26	Flu vaccine (annually) Human papillomavirus (HPV) vaccine All sexually transmitted infections testing Tetanus-diphtheria booster (should receive every 10 years)
27-49	Flu vaccine (annually) Cholesterol testing (begin at age 35 at five-year intervals thereafter) Type 2 diabetes screening (begin at age 45 and every three years after) Tetanus-diphtheria Booster (should receive every 10 years)
50+	Flu vaccine (annually) Cholesterol testing (at five-year intervals) Colorectal cancer screening (begin at age 50) Prostate exam Shingles (zoster recombinant) vaccine (two doses starting at age 50) Tetanus-diphtheria booster (should receive every 10 years) 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" and is based on the recommended schedules for your child's age and health history. Five categories are covered under the EPSDT program and include routine checkups, 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 annually from ages 3 through 6, and again at ages 8, 10, 12, 15 and 18. Hearing tests are provided at the newborn visit and annually from ages 4 to 6 and again at ages 8 and 10.

Developmental screening tests to assess how your child is growing and developing are performed at 9 months, 18 months and 24-30 months of age. Autism screenings should be conducted at the 18-month and 24-month visits. Dental screenings should also be performed prior to your child's third birthday. Separate blood tests for lead screening may be ordered when your child is 12 and 24 months old. If your child is over 24 months old and has not yet received a lead screening, your doctor may order one up until your child is 7 years old. Your child should receive the test 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 your doctor discovers a problem during any part of the exam or screenings, they 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, do not pay the bill. Call the phone number on the bill and give them the information on the back of your CountyCare member ID card. If you have any problems, call Member Services immediately at 312-864-8200 / 855- 444-1661 (toll-free) / 711 (TDD/TTY) for help. Member Services may recommend that you file a complaint to help resolve the issue.

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 through Friday from 8 a.m to 6 p.m. and Saturday from 9 a.m. to 1 p.m.. 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 medical services and 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. Covered medical services can also be found in the Certificate of Coverage.

- Abortion services are covered by Medicaid (not CountyCare) by using your Illinois Healthcare and Family Services (HFS) medical card
- Advanced practice nurse services
- Applied Behavior Analysis (ABA) therapy and services
- Ambulatory surgical treatment center services
- Assistive/augmentative communication devices
- Audiology services
- Blood, blood components and the administration thereof
- Chiropractic coverage for members ages 21 and over
- Dental services, including oral surgeons
- Doula services
- EPSDT services for members under age 21
- Family planning services and supplies
- Federally Qualified Health Centers, rural health centers and other encounter rate clinic visits
- Gender-affirming care
- Genetic counseling and testing
- Home health agency visits
- Hospital emergency department visits, inpatient services and ambulatory services
- Laboratory and X-ray services
- Lactation counseling services
- Medical supplies, equipment, prostheses and orthoses
- Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option and Targeted Case Management Option
- Nursing facility services
- Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for members under age 21
- 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
- Practice visits for members with special needs
- Renal dialysis services
- Respiratory equipment and supplies
- Services to prevent illness and promote health
- Skilled nursing
- Subacute alcoholism and substance abuse services, residential day treatment and detox day treatment
- Transplants*
- Transportation to covered services
- Vision services

* CountyCare Access (HBIS) coverage is limited to stem cell transplants and kidney transplants. No other transplant organ is covered for this group.

New Technology

New technology can be used to improve your care and your health. It can include:

- Medical tests and gadgets

- Mental health services
- Pharmacy technology

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.

Non-Covered Services

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

- Services that are experimental or investigative in nature
- Services that are provided by a non-network provider and not authorized by your health plan
- Services that are provided without required prior authorization
- Elective cosmetic surgery
- Fertility care
- Any service that is not medically necessary
- Services provided through local education agencies

If you are unsure whether a certain service is covered, please contact Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY). We will be able to tell you.

CountyCare Rewards & Extra Benefits

As a CountyCare member, you get extra benefits on top of your regular health care coverage. These include:

CountyCare Rewards Card

What is it?

The CountyCare Rewards Card Program lets you earn cash rewards for completing certain healthy activities. You can use these rewards to pay for what you need, including groceries, transportation, utilities and more at most places that accept Visa.

How it works:

When you or your children go to the doctor for certain services, your provider submits a claim to CountyCare which tells us that you received that qualifying service. Your provider has up to six months (180 days) to submit a claim to us. Once the claim is received and processed, the reward will be provided within 30 days.

CountyCare will send you a CountyCare Visa Rewards card in the mail the first time you earn a reward. Once you activate the card, you can use it at most places that accept Visa. Your card won't buy alcohol, tobacco or firearm products. Anytime you receive an eligible service and your claim is submitted, CountyCare will credit your existing card with the related reward amount.

Members have six months from the date the reward is added to their card to use the credit. After six months, the reward will expire. If you lose your card, call CountyCare Member Services immediately to close the card and have a new one sent. You can also report any missing or stolen funds, but there is no guarantee that Visa will return them.

If it has been longer than the above timeframes or if you have more questions, contact CountyCare Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY) for help.

If you use this program for rent or utilities, Housing and Urban Development (HUD) requires it to be reported as income if you seek assistance. Contact your local HUD office if you have questions.

Eligible Services and Amount Earned

PCP Annual Visit - $25 reward

CountyCare will give each member ages 16 months and older a $25 reward for seeing their assigned primary care provider (PCP) for an annual checkup.

Annual Health-Risk Screening - $15 reward

CountyCare will give each member a $15 reward once a year for completing a health-risk screening. Call Member Services to be connected with your care coordinator and complete the screening.

Notification of Pregnancy - $50 reward

Members who are pregnant can earn a $50 reward when they complete the Notification of Pregnancy form at www.countycare.com under "Brighter Beginnings".

Pre- and Postnatal Visits - $50/$10 rewards

Pregnant members should regularly see their doctor during their pregnancy and after baby is born.

- $50 reward per prenatal visit in the first trimester
- $10 reward for visits after the first trimester. Pregnant members can earn rewards on up to 14 visits for their entire pregnancy.
- $50 reward for a visit to the doctor one to12 weeks after the baby is born

Well-Child Visit - $50/$10 rewards

Members up to age 15 months can earn the following rewards when they see their CountyCare doctor.

- $50 reward for a doctor visit within 30 days after birth
- $10 reward for each of the next five visits with their CountyCare doctor

Colorectal Cancer Screening - $50 reward

Members ages 45 to 75 can earn a $50 reward each year when they get a colorectal cancer screening.

Cervical Cancer Screening - $50 reward

Women ages 21-64 can earn a $50 reward each year when they get a cervical cancer screening.

Mammography Program - $50 reward

Women ages 45 to 74 can earn a $50 reward each year when they get a mammogram.

Managing Diabetes - $25 reward

Members with diabetes ages 18-75 can earn:

- $25 for completing an annual PCP visit and getting their blood tests and urine screenings
- $25 for completing an eye exam once per year

Statin Drug Fulfillment – $25 rewards

Members ages 18-75 who fill a prescription for statin drugs for the first time

Aftercare/Follow-up Visits - $50/$100 rewards

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

- $100 for seeing your doctor within seven days after an emergency room visit for behavioral health, or
- $50 if it is more than seven days, but within 30 days after an emergency room visit for behavioral health
- $100 for seeing your doctor within seven days after an inpatient behavioral health stay, or
- $50 if it is more than seven days but within 30 days after an inpatient behavioral health stay

Annual Flu Shot - $10 /$75 rewards

Members should get a flu shot once a year from their PCP or an in-network pharmacy.

- Members ages 6 to 24 months can earn a $75 reward.
- Members ages 2 years and older can earn a $10 reward.

Immunizations for Babies - $10 rewards

Members under age 2 can earn a $10 reward for each immunization they receive (excluding the COVID vaccine).

COVID-19 Vaccine - $25 reward

Members ages 50 and older can earn a $25 reward for getting their annual COVID-19 vaccine.

HPV Vaccine - $25/$50 rewards

Members ages 9-45 who receive both human papillomavirus (HPV) vaccines at least 146 days apart can earn $25 for the first dose and $50 for the second dose.

Meningococcal Vaccine and Booster - $25/$10 rewards

Members ages 11 and older who receive the meningococcal vaccine and booster can earn $25 for the first vaccine and $10 for the booster.

Tentanus, Diphtheria and Pertussis (Tdap) Vaccine - $25 reward

Members ages 10-13 years who receive the Tdap vaccine can earn $25.

Completion of Care Management Satisfaction Survey – $15 reward

Members enrolled in Care Management who complete the care coordination satisfaction survey can earn $15 each year that the survey is completed.

A few reminders about the CountyCare Visa Rewards card:

- Keep your card! We will add more rewards as you earn them.
- Get the free smartphone app – You can keep up with the CountyCare Rewards Program on your phone. Download the OTC Network app to check your balance and more. It works for Apple or Android.
- 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 ages 21-45 who meet 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 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Free Diapers

We will send you a $10 digital coupon for diapers each month when your baby (up to age 2) is on schedule for shots.

Free Sleep Safe Kit

Pregnant or postpartum members can call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) and request a Sleep Safe Kit. We recommend calling in the third trimester so you're ready when the baby is born.

CountyCare will ship the free Sleep Safe Kit to their home, including a portable crib with a fitted sheet, sleep sack, baby book and pacifier.

Free Car Seat

Pregnant women and children up to age 8 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 members are encouraged to call a month before their due date so that the seat arrives in time for the baby's birth.

Book Club for Kids

Members ages 3 through 16 can sign up for our Toddler and Children's Book Club. CountyCare will mail kids a new book every three months. Call Member Services to enroll your child(ren).

Free Home Pregnancy Test

Female members of childbearing age can call Member Services and request up to one test per month. Money will be added to their rewards card so they can purchase a test, or a test 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.

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

Covered Home and Community-Based Services (HCBS OR "Waiver Services")

CountyCare operates five HCBS waiver programs through the Illinois Department of Healthcare 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 an institution or nursing facility. These HCBS waiver services are available in addition to medical and behavioral health benefits. 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. After taking the assessment, you will receive an overall DON score , which will determine your eligibility.

The five HCBS waiver programs currently operated by CountyCare include:

WAIVERS
Aging Waiver For people ages 60 and older who are at risk of nursing facility placement
Persons with Disabilities Waiver For people that have a physical disability, are between ages 18-59 and are at risk of nursing facility placement
HIV/AIDS Waiver For people of any age who 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 ages 22-64 with a physical disability or 65 ages or older and would otherwise be in a nursing home

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), including fall and GPS options
- 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
- Intermittent nursing
- 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 care
- Specialized medical equipment and supplies

Division of Rehabilitation Services (DRS)

Persons with Brain Injury:

- Adult day service
- Adult day service transportation
- Environmental accessibility adaptations for your home
- Supported employment
- Home health aide
- Intermittent nursing
- Skilled nursing (registered nurse (RN) and licensed practical nurse (LPN))
- Occupational therapy
- Physical therapy
- Speech therapy
- Pre-vocational services
- Habilitation (day)
- Homemaker
- Home-delivered meals
- Individual provider/personal assistant
- Personal emergency response system (PERS)
- Respite care
- Specialized medical equipment and supplies
- Behavioral services (MA and PhD)

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 require 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 support in place to ensure you are getting the care you need. If you are able, we have resources to assist you in transitioning 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.

Long-term care services, including nursing facility and home and community-based waiver services, are not covered for Health Benefits for Immigrant Seniors (HBIS) members in the CountyCare Access program.

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 Home and Community-Based (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 HCBS waiver services, like the ones listed above under "Covered HCBS Services," if you qualify

Dental Services

CountyCare covers all Medicaid-eligible dental services and more. You should visit your dentist regularly to prevent cavities and other problems. You must go to an in-network provider to receive dental services. 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).

If you have questions about specific services, please call Member Services.

Dental Benefits for Members Ages 20 and Younger:

- Dental exam and cleaning (one every six months)
- Braces (must be medically necessary, not for cosmetic reasons only)
- Fluoride treatment, oral surgery, X-rays, sealants, fillings, oral surgery, crowns (caps), root canals, dentures and denture repairs, extractions (pulling teeth) and emergency dental services
- In addition to covering all Medicaid-eligible dental services, CountyCare also covers:
  - Retreatment of root canals

Dental Benefits for Members Ages 21 and Older:

- X-rays, fillings, crowns (caps), oral surgery, extractions (pulling teeth), dentures and denture repairs and emergency dental services
- In addition to covering all Medicaid-eligible dental services, CountyCare also covers:
  - Dental exams and cleanings (one every six months)
  - Periodic orthodontic treatment visits, removal of braces and the construction of and placement of retainers for members who received their braces when they were age 20 or younger
  - Partial dentures
  - Root canals (all teeth)
  - Retreatment of root canals
- Pregnant members get regular checkups, cleanings and periodontal work (deep cleaning and tooth scaling).
- 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 visiting 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 covers all Medicaid-eligible vision services and more. You must go to an in-network provider to receive vision services. You can find a CountyCare vision provider by visiting our website, www.countycare.com, or by calling CountyCare Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

If you have questions about specific services, please call Member Services.

Your children's pediatrician or nurse will test their vision during a routine checkup. If you or your child's doctor has any concerns about their vision, you can take them to an eye doctor.

You get:

- All members get one exam from our network of optometrists and ophthalmologists every calendar year.
- All members can get one pair of eyeglasses every calendar year. You can choose from our standard selection of frames.
- As an added benefit, you can choose to receive a $125 allowance toward the retail value of your frames. If the frames cost more than $125, you are responsible for paying the difference in price.
- Additionally, all members can choose contact lenses instead of eyeglasses. The fitting fee is fully covered, and you get a $300 allowance toward the cost of your contact lenses. If the cost of your contact lenses is above $300, you are responsible for paying the difference in price
- If certain prescription requirements are met, single vision and bifocal lenses for your glasses are fully covered.

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 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).

Services are available at outpatient, inpatient and residential levels depending on the needs 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
- Applied behavior analysis (ABA) 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 primary care provider (PCP) or 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

Crisis and Referral Entry Services (CARES) is a telephone response service that handles mental health crisis calls for children, adults and families in Illinois. CountyCare members can use the 24-hour 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 800-345-9049 (TTY: 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. They do not have to be in our provider network. You do not need a referral from your primary care provider (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 checkups, laboratory screenings and ultrasounds and care for problems or complications of pregnancy or childbirth
- Inpatient hospital services at 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
- Breastfeeding education and support services provided by certified lactation consultants
- Support from certified doulas during pregnancy, labor and delivery and after birth to provide comfort, guidance and care

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 your doctor approves your discharge and makes an outpatient appointment for you and your 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 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 make sure your baby has health care coverage. Be sure to enroll your child within 45 days of birth. You can do this by logging into your ABE Manage My Case portal account: https://abe.illinois.gov/access/ or call the Illinois Department of Human Services at 1-800-843-6154. If you need help, call member services at 312-864-8200 and ask for your care coordinator. You will receive a notification in the mail from the state once your baby has been added.

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 Expectant Families:

- Prenatal visits: You can earn $50 on a CountyCare Visa Rewards card for going to prenatal visits in your first trimester and $10 for visits after the first trimester, up to 14 visits total.
- Postnatal visits: You can earn $50 when you see your provider for a checkup one to 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 immunizations your baby receives before they are age 2 (excluding the COVID vaccine).
- Flu shot: Earn a $75 reward when your child age 6 to 24 months receives their annual flu vaccine.
- Notification of pregnancy: Members who are pregnant can earn a $50 reward when they complete the Notification of Pregnancy form at www.countycare.com under "Brighter Beginnings."

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 pregnant members and children up to age 8. Call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY) to request a car seat, and it will be shipped to you.
- Sleep Safe Kit: Pregnant or postpartum members can call Member Services and request a Sleep Safe kit. The kit includes a portable crib with

fitted sheet, sleep sack, baby book and pacifier. We recommend calling in the third trimester so you're ready when the baby is born.

- 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.
- Diaper coupons: All families with a baby under age 2 will receive a $10 coupon once a month for a pack of diapers. CountyCare will send the digital 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, Walmart, and independent pharmacies. Make sure you have your CountyCare member ID card to show at the pharmacy.

If you see a Cook County Health provider, our pharmacies are available to fill your prescriptions. If your primary care provider (PCP) is part of a community health center, you may also be able to use their pharmacy to get your prescriptions.

You can see all the medications we cover on our County Care formulary. You can find the formulary on our website at www.countycare.com under "For Members." 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 your current medications for your first 90 days with us. Within these 90 days, discuss your medications and our CountyCare formulary options with your doctor. Some children with special health needs may continue their current medications for their first 180 days with us.

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 offers transportation to and from doctor appointments for covered services. You can also get rides to and from:

- Pharmacies
- Medical equipment providers
- Behavioral health and substance use treatment appointments
- Women, Infants and Children (WIC) food assistance sites
- Certain events sponsored by CountyCare

You can:

- Ask for public transportation passes (Ventra and PACE) two weeks before your appointment
- Schedule a ride. You will need to do it at least 72 hours (three days) before your appointment. You can schedule a ride by:
  - Calling Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY)
  - Using the self-service web portal
  - Downloading and using the Modivcare mobile app

Ambulance Transportation

Emergency Ambulance Coverage

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

Non-Emergency Ambulance Transportation Criteria

Effective Jan. 1, 2022, the Illinois Department of Healthcare and Family Services Fee-for-Service (HFS FFS) will schedule all non-emergency ambulance

trips. CountyCare will no longer be scheduling these trips. Transdev Fee-for-Service (FFS) may contact you to get information on what services you need, but they will not schedule ambulance trips.

If you need non-emergency ambulance services, follow these steps:

- Call Transdev FFS directly at 877-725-0569 (Monday through Friday, 8 a.m. to 5 p.m. Central Time).
- Transdev FFS will initially verify your eligibility. They will ask some questions to see if you meet the criteria.
- If you are eligible, Transdev 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 Transdev FFS again for help.
- If you are not eligible for a non-emergency ambulance, please contact Transdev FFS transportation at 877-725-0569 to make other plans.
- You will need to contact Transdev FFS again to finalize the trip.
- A Physician Certification Statement (PCS) form is needed for all ambulance trips that are not for emergencies.

Only non-emergency ground ambulance transportation services will be moving from CountyCare to Transdev FFS. All other transportation requests (air ambulance, Medicar, service car, taxi and private auto) will remain the same.

You can call CountyCare Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TTY/TDD) with any questions. You can also contact the HFS Bureau of Professional and Ancillary Services at 877-782-5565 for fee-for-service issues.

Care Coordination

CountyCare care coordinators provide education and personal help to our members to improve their health. They can also help you with medical and behavioral needs that may affect your health. Care coordinators can connect you to community resources. Our staff members work with you to make sure your care is respectful of your cultural beliefs, spoken language and preferences. The goal of this service is to add to the quality of your care and support you. 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 with:

- Communication between you, your caregiver and your health care providers
- An assessment of your conditions
- Care planning by helping you set your short-and long-term goals based on what matters most to you
- Organizing your care to make sure you get the services you need on time
- Helping you manage any chronic conditions

A CARE COORDINATOR is a resource person who:

- Answers your questions
- Shares their knowledge of the health care system
- Helps you consider your options and choices
- Helps with treatment referrals at health care facilities
- Identifies covered benefits
- Helps plan your transition out of the hospital
- Connects you with community resources
- Visits you at a health care facility or where you live
- Helps you make an emergency back-up plan if your care, services, or equipment are affected

The information obtained through our care

coordination process is confidential. It is shared only when needed to help plan your care or to properly pay for your services.

Need help finding your care coordinator? Fill out the online form or call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Population Health Management Programs

Health Screening, Assessment and Care Plan

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 Individual Plan of Care (IPoC) can include anything that will help you: appointments with providers; education about medical conditions; access to sources of food, clothing, transportation, housing or job training; arrangements at your child's school; or steps you want to take to improve your health or prepare for the future. The information we get from you is confidential, and we will only share it with people who will help coordinate your care. 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. You can also request the following from a care coordinator:

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

Programs for People with Special Conditions

We 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

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 print a copy of your answers and show them to your health care provider if you see something you want to discuss.

If you have trouble using these tools, you can call your care coordinator for help.

Care Management Member Rights and Responsibilities

A member can agree to be enrolled in a care coordination program. It is also known as "case management." In this program, your care coordinator will work closely with you to support you and help you improve your health.

Member Rights

You are able to use your rights without any action taken against you. As a CountyCare member, you have the right to:

1. Have information about CountyCare, our programs, 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 and 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 and discuss these services with your provider.
6. Have your medical information kept safe, know who has access to your information and 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 and 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 Individualized Plan of Care (IPoC).

Member Responsibilities

As a CountyCare member, you have the responsibility to:

1. Follow the instructions and 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. Hostile or threatening behavior may make it difficult for your care manager to do their job.
3. Follow participation requirements.
4. Give CountyCare the right information so we can provide you with the services you need. Let CountyCare and your provider know if you leave the CountyCare care management program.
5. 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 whenever they would like to 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 of services 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 not threatening or acting abusively toward the provider

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 Managed Long-Term Services and Supports ([M] LTSS) HCBS member's consent for treatment must be documented, as well as a written acknowledgement of their rights and responsibilities, which include:

- To be educated on their member rights annually and when care services begin or change
- To choose their health care providers and the types of services they receive
- To refuse treatment or services and be informed of potential impacts on their benefits eligibility and/or health outcomes

- To report abuse, neglect and exploitation at the time of the assessment and reassessment and to be informed of how and to whom to report these incidents
- To use end-of-life and advance care directives
- To receive notification and rationale when care coordination services are changed or terminated
- To access 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 assess ourselves every year to see what is going well and what could be going better through our quality improvement (QI) program.

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
- A complaint about service

Our QI program team members take many steps to improve your care, including:

- Assessments of preventive care and care for specific health conditions
- Member satisfaction surveys on the health care and services they have received
- Investigation of quality-of-care grievances

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 Illinois Department of Healthcare and Family Services (HFS) and CountyCare to make certain our members best use the services available to them. The goal of this program is to encourage strong patient-health care provider relationships by connecting members with care managers who can help coordinate care and support appropriate use of pharmacy services. This program assigns a member to a specific primary care provider (PCP) or pharmacy. Members receive a written notice of the lock-in and are given the opportunity to appeal the lock-in determination within 60 days of the notice letter.

Advance Directives

You have a right to make decisions about your medical care. An "advance directive" is a written declaration you make about your future health care in the event that 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 Illinois Department of Public Health (IDPH) website: https://bit.ly/idphpowerofattorneyhealthcareform
- **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)** - This tells your family, 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 if you have one. You do not have to have one to get 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 them at any time.

You can state your medical care wishes in writing while you are healthy and able to make decisions. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. The facility 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 one. Anyone age 18 or older who is of sound mind and can make their 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 or your care coordinator for an advance directive form or help filling it out. The IDPH website also has helpful information regarding advanced directives. You can find those resources here:
https://bit.ly/idphadvancedirectives

Grievance & Appeals

We want you to be satisfied with the 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 Illinois Department of Human Services Office of Rehabilitation Services 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 got a medical bill you shouldn't have received.

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: 312-548-9940

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 CountyCare 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 to you at no cost. Please include this request when you file your grievance. If you are hearing impaired, call the Illinois Relay at 711.

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

To appoint someone to represent you, either:

1. Send a letter informing us that you want someone else to represent you and include in the letter their contact information, or,
2. Fill out the Authorized Representative form. You may find this form on our website at https://bit.ly/authorizedrepresentativedesignation

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 an Adverse Benefit Determination letter from us. This letter will tell you what action was taken and the reason for it. It will also explain your right to:

- File an appeal and be informed of how to do it
- Ask for a State Fair Hearing and be informed of how to do it
- Ask for an expedited appeal in some circumstances and be informed of how to do it
- Request to have benefits continue during your appeal and be informed of how to do it and when you may have to pay for services

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 no later than **10 calendar days** from the date on our Adverse Benefit Determination letter. You may want to file an appeal when your health plan:

- Does not approve or pay for a service or item your provider asks for
- Stops a service that was previously approved
- Does not give you the services or items in a timely manner
- Does not advise you of your right to choose providers
- Does not approve a service for you because it was not in network

Here are two ways to file an appeal:

1. 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 up with a written and 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: 312-548-9940

If you do not speak English, we can provide an interpreter to you at no cost. 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 a letter informing us that you want someone else to represent you and include in the letter their contact information, or
2. Fill out the Authorized Representative form. You may find this form on our website at https://bit.ly/authorizedrepresentativedesignation

Appeal Process

After you file an appeal, we will send you a letter within three calendar days acknowledging we received it. We will tell you if we need more information and how to give us this 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 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 a decision notice. This will explain what we will do with your case and why.

If CountyCare's decision agrees with the Adverse Benefit Determination, you may have to pay for the cost of the services you received 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 can choose to be present when CountyCare reviews your appeal.

How can you expedite your appeal?

If you or your provider believes our standard review timeframe of 15 business days 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 an 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 a decision notice.

How can you withdraw an appeal?

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

However, you or your authorized representative must do so in writing, using the same address you used when filing your appeal. Withdrawing your appeal will end the process, and we will not take any further action on on your 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 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 ask for a State Fair Hearing Appeal and/or 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. 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 the services provided to you during the appeal process.

At the State Fair Hearing, just like during the CountyCare appeal 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 a letter informing us that you want someone else to represent you and include their contact information in the letter.

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/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, view important dates and notices related to the State Fair Hearing and submit documentation.
- If you want to file a State Fair Hearing Appeal related to your medical services or items or Elderly waiver (Community Care Program) services, send your request in writing to:

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

- You may also file a State Fair Hearing Appeal by calling the Illinois Department of Healthcare and Family Services at 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 St., 4th Floor
Chicago, IL 60602
Fax: (312) 793-8573
Email: DHS.HSPAppeals@illinois.gov
Or you may call
(800) 435-0774, TTY: (877) 734-7429

State Fair Hearing Process

The hearing will be conducted by an impartial hearing officer authorized to conduct State Fair Hearings.

You will receive a letter from the appropriate hearings office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully. If you set up an account at https://abe.illinois.gov/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 that 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 (rescheduling)

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you or your authorized representative does 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 involved in 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 that reasonably would prohibit your appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the hearings office will send a letter with the new date and time to you or your authorized representative, and all parties involved in the appeal.

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

The State Fair Hearing Decision

A final administrative decision will be sent to you and all involved 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 by the circuit courts of the State of Illinois. The time the circuit court allows for filing a review may be as short as 35 calendar days from the date of the decision 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 similar specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Does 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 Persons who are 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 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: 312-548-9940

What Happens Next?

- We will review your request to see if it meets the qualifications for an external review. We have five business days to do so. If it does, we will send you a confirmation letter with the name of the external reviewer assigned to your case.
- You have five business days from the letter we send you to submit 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 and/or your authorized 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 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 once for an external review about a specific action.

CountyCare Health Plan
P.O. Box 21153
Eagan, MN 55121
Fax: 312-548-9940

What Happens Next?

- Once we receive a phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies. If it does, we will contact you and/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 needed information, the external reviewer will make a decision about your request. They will verbally let you and/or your representative and CountyCare know what their decision is. They will also follow up with a letter including the decision to you and/or your authorized representative and CountyCare within 48 hours.

Rights & Responsibilities

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

Member Rights:

- Be treated with respect and dignity at all times, no matter your background, race, ethnicity, immigration status, culture, religious beliefs, language, sexual orientation or gender identity.
- Have your personal health information and medical records kept private, except in instances allowed by law.
- Be protected from discrimination of any kind.
- Be free from the use of any form of restraint or seclusion to force, control or ease reprisal or retaliation.
- Receive information in other languages or formats (such as audio, large print or Braille) at no cost, including the CountyCare member handbook.
- Have a free interpreter when needed, including during any complaint or appeal process.
- 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, including the right to ask for a second opinion. Providers must explain your treatment options in a way you understand.
- Receive the information you need to be involved in making decisions about your health care treatment.
- 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") 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.
- Request information about CountyCare Health Plan and its providers, services

and policies and receive this information in a reasonable amount of time.

- Receive information about CountyCare Member Rights and Responsibilities and suggest changes to this policy.
- Receive health care services that follow federal and state law. Covered services must be available 24 hours a day, seven days a week.

Member Responsibilities:

- Treat CountyCare staff, your doctor and office staff with courtesy and respect.
- Carry your CountyCare member ID card with you when you go to your doctor's appointments and 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 about your health as possible so that CountyCare and their providers can best care for you.
- Know your health conditions 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 Member Services.

Fraud, Waste and Abuse

Reporting fraud, waste and abuse (FWA) is the responsibility of everyone.

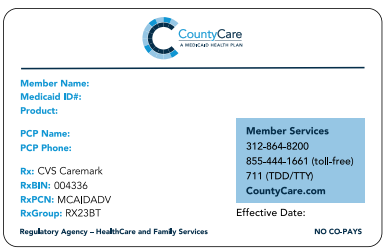
Let us know if you think a health care provider or a person getting benefits is doing something wrong. This could be fraud, waste or abuse, which is against the law.

- "Fraud" is when someone receives benefits or payments that they do not qualify for or that they lied to obtain.
- "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, including actions that result in extra or unreasonable costs.

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 treatment
- Misusing their plan benefits
- Letting someone use their CountyCare member ID
- Using someone else's CountyCare member ID
- Not telling the truth about the amount of money or resources they have so they can receive benefits



CountyCare will send you letters from time to time to ask you to confirm that you received health care services. Please review and answer these letters. This helps us prevent 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 (toll free) / 711 (TDD/TTY)
Illinois Department of Healthcare and Family Services (HFS) Medicaid/Welfare Fraud Hotline	844-453-7283 / 844-ILFRAUD https://hfs.illinois.gov/oig/reportfraud.html
Illinois Department of Human Services (DHS) Office of the Inspector General	800-368-1463 https://www.dhs.state.il.us/page.aspx?item=29410
Illinois Department on Aging Elder Abuse Line (not in a nursing home)	866-800-1409 / 888-206-1327 (TTY) https://www.dhs.state.il.us/page.aspx?item=32675
Illinois Department on Aging Senior Helpline	800-252-8966 https://ilaging.illinois.gov/protectionadvocacy/abuse-reporting.html

Please find additional information on reporting allegations of fraud, abuse or neglect at the following website: https://www.dhs.state.il.us/page.aspx?item=32675

Health, Safety, Welfare, Reporting and Follow-up of Incidents

The State of Illinois has laws to protect the health, safety and welfare of vulnerable adults. These laws may apply to critical incidents where a caregiver or other trusted person causes harm or creates a serious risk of harm to a vulnerable adult, even if the harm is not intentional.

Types of Critical 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 necessary services to maintain the physical and or mental health of a vulnerable adult

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

Critical Incident Reporting Requirements

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

How to Report a Critical Incident

Critical incidents involving CountyCare members can be reported to CountyCare by filling out a critical incident report using the link below or calling Member Services at **312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).**

Link: https://cmis.cookcountyhealth.org/criticalincident.html

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

- **For members ages 18-59 with a disability or ages 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 age 18:**
  - *Illinois Department of Children & Family Services (DCFS)* Hotline
  - General telephone number: **800-252-2873 (voice) TTY: 800-358-5117.** ***For non-DCFS membership***.
- **For members in nursing facilities:**
  - *Illinois Department of Public Health Nursing Home Complaint*
  - Hotline telephone number: **800-252-4343**
- **For members ages 18-59 receiving mental health or developmental disability services in programs operated, licensed, certified or funded by the Illinois Department of Human Services:**
  - *Illinois Department of Human Services Office of the Inspector*
  - General telephone number: **800-368-1463 (voice and TTY)**
- **For members in supportive living facilities (SLF):**
  - *Illinois Department of Healthcare and Family Services SLF*
  - Hotline telephone number: **800-226-0768**

If you or a family member witnesses, is told of or suspects an incident of abuse, neglect or financial abuse or any other event that may place the member or their health 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 causes
- Poor coloration or sunken eyes or cheeks
- Soiled clothing or bed
- Lack of necessities such as food, water or utilities
- Wearing the same clothing all of the time
- Fleas or lice on an individual
- Unkempt, dirty appearance
- Hair matted, tangled or uncombed

Financial abuse signs to look for:

- Accessing an 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 Medical Transportation means ambulance services for an emergency medical condition.

Emergency Room Care means the emergency services you get in an emergency room.

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

Excluded Services means health care services that your health insurance or plan does not 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 is not 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.

Health Insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Plan means an organization made up of doctors, hospitals, pharmacies, providers of long-term services and other providers. It also includes care coordinators to help you manage your providers and services. They all work together to provide the care you need.

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

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

Hospitalization means care in a hospital that requires inpatient admission 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 does not 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.

Network means the facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Pharmacy means a pharmacy (drug store) that has agreed to fill prescriptions for our plan members. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider or "provider" or "plan provider" is the general term we use for doctors, nurses and other people who give you services and care. The term also includes hospitals, home health agencies, clinics and other places that give you health care services, medical equipment and long-term services and supports.

- They are licensed or certified by the Centers for Medicare and Medicaid Services and by the State of Illinois to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services.

Non-Participating Provider is a provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-participating provider. Check your policy to see if you can go to all providers who have contracted with your health insurance plan or if your health insurance or plan has a tiered network and you must pay extra to see some providers.

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.

Participating Providers agree to work with the health plan, accept payment and not charge members an extra amount. While you are a member of our plan, you must use participating providers to get covered services. Participating providers are also called "network providers."

Physician Services are health care services a licensed medical physician (e.g., M.D. – medical doctor, D.O. – doctor of osteopathic medicine) provides or coordinates.

Plan is the pairing of health insurance benefits under a product, provider network and service area.

Preauthorization or 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 prior-authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Prior authorization is not a promise your health insurance or plan will cover the cost.

Premium means the amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

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

Prescription Drugs means drugs and medications that require a prescription by law.

Primary Care Physician means a physician (e.g., M.D. – medical doctor, D.O. – doctor of osteopathic medicine), as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Primary Care Provider means a physician (e.g., M.D. – medical doctor, 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. This also includes the treatment you get to help you recover from an illness, accident or major operation. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. Call Member Services to learn more about rehabilitation services.

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.

Skilled Nursing Facility (SNF) Care means the skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist 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, etc.)
- 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 or to request a printed

copy of materials, please contact Member Services at CountyCare: Phone: 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

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

CountyCare Grievance & Appeals Coordinator
Attn: Grievance and Appeals Dept.
P.O. Box 21153
Eagan, MN 55121
Phone: 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY
Fax: 312-548-9940
Electronically: http://www.countycare.com/members/portal

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 and 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/sites/default/files/ocr-cr-complaint-form-package.pdf

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).

Español/Spanish:

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

Polski/Polish:

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

中文/Chinese:

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

한국어/Korean:

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

عربي /Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل 1661-444-855 / 8200-864-312 / 711 رقم هاتف الصم والبكم:

Русский/Russian

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

ગુજરાતી/Gujarati

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

اُردُو/Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال 312-864-8200 / 855-444-661 (TTY: 711).

Tiếng Việt/Vietnamese

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

हिन्दी/Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 312-864-8200 / 855-444-1661 (TTY: 711) पर कॉल करें।

Français/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).

Українська/Ukranian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної

підтримки. Телефонуйте за номером 312-864-8200 / 855-444-1661 (телетайп: 711).

বাংলা/Bengali

দৃষ্টি আকর্ষণ: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। কল করুন 312-864-8200 / 855-444-1661 (টোলমুক্ত) / 711 (TTY)।

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 ("us", "we") may use and share your health information and demographic information including but not limited to your race, ethnicity, language or sexual orientation. This notice also describes your rights to access your information and our responsibilities to protect it. We must keep your health information private and secure.

What Is Health Information?

"Health information" means any information related to your health care that identifies you. Examples include but are not limited to 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 protect the privacy of your health information and provide you with information on how we use and share it. We are also required by law to give you this notice. These state and federal laws strengthen our commitment to you as our member to carefully maintain and safeguard your confidentiality. Although it is not health information, we also apply the same privacy and protection to your demographic information such as race, ethnicity, language and sexual orientation. We will not use or share your information other than as described here, unless you tell us we can in writing. Your demographic information will not be used for denial of services, coverage or benefits. 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 and Demographic Information

To Manage Your Health Care Treatment. We will use and share your 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 and demographic information (such as your preferred language) 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 and assess how well we are doing it. We may contact you when necessary or if you have opted in to being contacted.

> **For Example:** We will 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 of Illinois to show we are following our contract.

To Pay for your Health Services. We may 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 that have a contract with CountyCare for plan administration.

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

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 and demographic information private and secure.

How We Can Use or Share Your Health and Demographic Information with Your Permission

You can choose how we use and 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 any other person you tell us is involved in your health care or who helps pay for it. You have the right to ask that we not share your information with certain people, but you must let us know. In an emergency situation or other circumstance where you are not able to tell us your preference, we may share some information with family, friends or others if we believe it is in your best interest.

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 provide you information through a general newsletter, in person or by way of products or services of nominal value. We may share your health information with a business associate to assist us in these activities. We may contact you by email or text message for appointment reminders, member surveys, wellness program benefits or other general communications and health care content if you provide us with your email address and/or mobile phone number. Contact may be made by phone call, email or text message if you have provided those methods of contact. You may reach out to us and specifically request that we do not contact you via any of those methods. We may not sell your health information without your written permission.

With Parents and Legal Guardians of Minors. We may disclose health information about minor children to their parents or legal guardians, unless such disclosure is prohibited by law. If a minor is emancipated, married, pregnant or a parent, we will not share the minor's information with their parents or legal guardians without the minor's permission. If a minor is receiving care for certain sensitive conditions, such as HIV/AIDS, mental health conditions, reproductive care and others, we will not disclose this information to the minor's parents or legal guardians without permission, unless required or allowed by law.

To Perform Research. We may use and disclose your health information for research purposes. Most research projects, however, are subject to a special approval process and require your permission if a researcher will be involved in your care or will have access to your name, address, or other information that identifies you. The law allows some research to be done using your health information without requiring your authorization.

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 or if we are required by law to share your information. We have to meet many legal conditions in the law before we can share your information for these purposes.

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

For example:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect
- To help report information to the U.S. Food and Drug Administration (FDA) about products it oversees;
- 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.

With Law Enforcement. We will share health information about you when we are required to do so by federal, state or local law, or by the courts.

For example:

- To respond to a court order, warrant, summons or other similar process;
- To identify or locate a suspect, fugitive, material witness or missing person; or
- To obtain information about an actual or suspected victim of a crime.

We may share information with a law enforcement official:

- If we believe a death was the result of a crime;
- To report crimes on our property; or
- In an emergency.

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.

During an Investigation. We will share your information with the Secretary of the U.S. Department of Health and Human Services if they ask for it as part of an investigation of a privacy violation. Under the same laws, we must give you records about yourself that you request. In some limited circumstances, we are allowed to keep some information from you.

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

- Authorized federal officials;
- Armed forces command authorities or federal agencies to see if you are fit for military duty, eligible for veteran's health benefits or medically fit to receive a security clearance;
- For intelligence, counter-intelligence, and other national security activities; and
- To protect the President of the United States.

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 health information to prevent or reduce a serious threat to your health and safety or the health and safety of others.

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 oversee health care systems and government programs 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.

How We Protect the Use of Your Information

How We Keep Your Information Safe. We take steps to protect your health and demographic information and keep it private. We use both physical and electronic safeguards to protect your health information, including secure computer systems, access and password controls, employee minimum necessary and use restriction policies, and mandatory employee and vendor training.

Your Rights Regarding Your Health and Demographic Information

You Have the 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. However, we do not have to agree to the request. We must agree to the request if the disclosure is for the purpose of carrying out payment or for health care operations and is not otherwise required by law. We must also agree to the request if the health information is only about a health care service or item that you or a person other than your health plan has fully paid for on your behalf. You may also ask us to limit the information that we use or share with your family members, friends or any other person who you tell us is involved in your care or helps pay for it.

You must submit your request in writing, and it must be signed and dated. You should describe the information you want to limit and tell us who should not receive this information. You must submit your written request to CountyCare Health Plan, Attention: Compliance, 1950 W. Polk St., 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 the Right to Get a Copy of Your Designated Record Set. You have the right to read or get a copy of your designated record set that we have about you.

To see and obtain copies of this information, you must make a request in writing. We will give you a copy or a summary of your designated record set within 30 days of your request. If you request a copy of your designated record set, we may charge a reasonable fee for the costs of copying, mailing or other activities associated with your request.

You Have the Right to Request Changes. You may ask us to change your health information, demographic, 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 if you disagree with us. It will be attached to the information you wanted changed or corrected.

You Have the 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 the Right to an Accounting of Disclosures. You have the right to make a written request for a list of the times we have 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 disclosures, except for those about treatment, payment and health care operations or any disclosure you asked us to make. We'll provide one accounting per year for free but will charge a reasonable fee if you ask for another within 12 months. Your written request must specify a time period for these disclosures.

You Have the 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 one promptly.

You Have the 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. If you have chosen someone to act for you, you must provide a copy of the documentation giving that person authority to act for you.

Reproductive Health Information. We will not use your health information to conduct or assist others in conducting investigations or imposing penalties on you for the mere act of seeking, obtaining, or facilitating reproductive health care that is lawful. In instances where we receive requests for your health information that may include reproductive health information for health oversight activities, judicial or administrative proceedings, law enforcement purposes or disclosures to coroners and medical examiners, we will obtain a signed attestation from the requestor stating that their request is not for a prohibited purpose.

We will inform them that improper uses and disclosures of your health information may result in criminal penalties.

Genetic Information. We are not allowed to use genetic information to decide whether we will give you coverage or the price of that coverage.

Substance Use Disorder (SUD) Treatment Information. If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a consent you provide to that Program to use and disclose the Part 2 information for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 information for those same purposes. This is consistent with HIPAA requirements and uses and disclosures described in this Notice. If we receive or maintain your Part 2 information through specific consent you provide to us or another third party, we will use and disclose your Part 2 information only as permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 information, or testimony on information contained in your Part 2 Program record in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by you or the order of a court after it provides you notice of the court order.

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.

Other Uses and Disclosures of Your Health Information

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

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 U.S. Department of Health and Human Services Office for Civil Rights. You can do so by sending a letter to:

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

You can also call 877-696-6775, or you may visit https://hhs.gov/hipaa/filing-a-complaint/ to file a complaint.

You can contact the Cook County Health Office of Corporate Compliance and/or the Cook County Health Privacy Officer to discuss any concern you have using the information below:

Cook County Health & Hospitals System
1950 West Polk St., Suite 9217
Chicago, IL 60612
Telephone: 1-877-476-1873
compliance@cookcountyhhs.org

Your Care Coordinator

You can contact your care coordinator at 312-864-8200 / 855-444-1661 (toll- free), Monday through Friday. If you are hearing impaired, call our TDD/TTY line at 711.

It's important you keep in contact with your care coordinator. They 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

CountyCare
A MEDICAID HEALTH PLAN

MARCH 2026