CountyCare
A MEDICAID HEALTH PLAN

HealthChoice Illinois

MLTSS
Member Handbook

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

Welcome to CountyCare

Welcome to CountyCare Managed Long-Term Services and Supports (MLTSS). We are happy to have you as a member of CountyCare.

This program is for people who receive full Medicaid and Medicare benefits, live in a nursing facility or receive waiver services. Our MLTSS program helps you live as safely and independently as possible in the place you choose. You will receive your Medicaid-covered waiver or nursing facility services through CountyCare as well as some behavioral health services and non-emergency transportation. Members enrolled with CountyCare must live in Cook County.

CountyCare staff is available 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) to answer your questions.

We would like you to read everything in this packet and write down any questions you have. It explains:

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

To read the certificate of coverage scan the QR code. You can also request a copy by calling Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

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
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.。

Hearing Impaired Members

Call Illinois Relay at 711. Ask the operator to connect you to us at 312-864-8200 or 855-444-1661 (toll-free). Let your doctor know if you need a sign language interpreter for a medical visit. If your doctor does not have one, call us at least seven days before your visit to make arrangements for an interpreter to be present during your appointment.

Accessibility

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

Free Language Services

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

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

If you speak another language and need interpreter services, call 1-312-864-8200 or 1-855-444-1661 (toll-free) / 711 (TDD/TTY). We'll get you an interpreter in your language. We can also help if you need sign language interpretation. You can also use this service at your health care provider's office. This service is available at no cost to you. You can get this handbook in another language. Call Member Services at 1-312-864-8200 or 1-855-444-1661 (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).

Polish

Aby otrzymać ten Podręcznik Uczestnika w języku polskim skontaktuj się z naszym biurem obsługi pod numerem telefonu 312-864-8200 / 855-444-1661 (bez opłat) / 711 (TDD/TTY).

Other

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

Communication from CountyCare

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

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

You may also get e-mails, texts or phone calls reminding you of needed exams. 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 your Illinois Department of Human Services (IDHS) office informed of your current 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. Visit our website for resources and information, such as:

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

Our website is **www.countycare.com**

CountyCare's Secure Member Portal

CountyCare has a secure member portal where you can:

- Print a temporary ID card
- Send/receive secure messages to/from CountyCare
- Get personalized information

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

Table of Contents

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.
Saturday: 9 a.m. to 1 p.m.

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

- Your benefits, including the extra member incentives that CountyCare offers
- Your rights and responsibilities as a CountyCare member
- How to submit a grievance and an appeal
- State Fair Hearing procedures
- CountyCare's web address and the basic information included online
- Our certificate of coverage, which explains that we are contracted by the State of Illinois
- Our affiliated providers
- Ask questions or obtain information

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

You can contact CountyCare 24 hours a day, seven days a week by calling 312-864-8200/855-444-1661 (toll-free) / 711 (TDD/TTY).

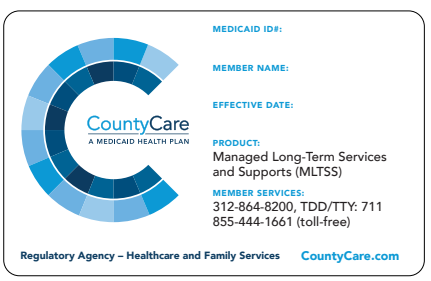
Expect a Welcome Call from Us

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

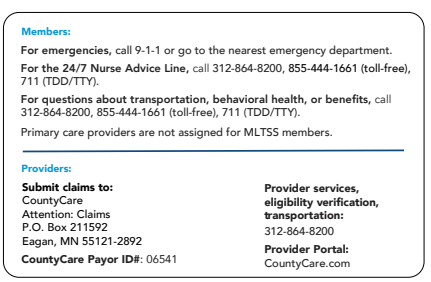
Member Identification (ID) Card

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 and your Medicare ID card with you. You may have problems getting assistance if you do not have the correct ID card with you. If you have other health coverage cards, bring them with you, too.



Front of Card



Back of Card

Updating Your Address and Phone Number

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

Open Enrollment

Once each year, you can change health plans during a specific time called "open enrollment." Illinois Client Enrollment Services (CES) will send you an open enrollment letter approximately 60 days prior to your anniversary date. Your anniversary date is one year from your health plan start date, 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. You can opt-out of MLTSS at any time if you enroll in Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP).**

If you have questions regarding your enrollment or disenrollment with CountyCare, please contact Client Enrollment Services (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 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.

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 has processed your redetermination, if you are still found to be eligible, your Medicaid coverage will be reinstated, 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 questions about how happy or unhappy you are with the services you are getting. Please take the time to respond. We value your opinion. It will help CountyCare to improve the service we provide.

Enrollee Advisory Committee

CountyCare invites our members to meet in person to share their opinions. During Enrollee Advisory Committee meetings, 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

Guidance on Medicare

Medicare is your primary source of health coverage, and CountyCare covers the following Medicaid services: long-term nursing home care, home and community-based waiver services, behavioral health, and non-emergency transportation. For questions related to your Medicare coverage, including benefits, claims or provider networks, please contact your Medicare payor directly. Your care coordinator can assist you if needed.

If you are unsure who your Medicare payor is, you may contact Medicare for assistance at 1-800-633-4227. TTY users may call 1-877-486-2048. Medicare representatives are available 24 hours a day, seven days a week.

Scheduling Appointments

It is very important that you keep all appointments and be on time. If you need help making an appointment, please contact your care coordinator or Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

If you cannot keep an appointment, please cancel it 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 your care coordinator or Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/ TTY).

Care Coordination

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

Your Care coordinator will help you with:

- Connecting to caregivers 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
- Coordination of services to provide necessary and efficient care

A Care coordinator is a resource person that:

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

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

Know how to find your care coordinator? Fill out this **form** or call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Provider Network

A "provider network" is the doctors, specialists, clinics and hospitals that health plans contract with to provide care to members. CountyCare has a large network of providers to choose from for the Medicaid services we cover for you. You can see which providers are in our network by going online to **www.countycare.com**. The provider directory displays each provider's name, address, telephone number, office hours, board certification status and spoken languages. You can call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TTD/TTY) for assistance with finding a

provider or to request a printed copy of the provider directory be mailed to you.

Your Provider's Office

When you see your provider, ask him or her and the office staff the questions listed below. By knowing these answers, you will be better prepared for getting covered services.

- What are your office hours?
- What kinds of special help do you offer for people with disabilities?
- If you're hearing-impaired, do you have a sign language interpreter?

If your provider's office doesn't have interpreters, CountyCare can provide you with one at no cost to you. Call us at 1-312-864-8200 or 1-855-4441661 (toll-free) / 711 (TDD/TTY) at least three days before your appointment and ask to arrange for sign language interpreter at your provider visit.

You can ask your provider these questions:

- Will you talk about problems with me over the phone?
- Who should I contact after hours if I have an urgent issue?
- How long do I have to wait for an appointment?

Copays

CountyCare members don't pay copays for any MLTSS services covered under our plan. Providers may not bill CountyCare members for any services or copayments. If you receive a bill from a provider, call Member Services at 312-864-8200 / 855-444-1661 (toll-free) / 711 (TDD/TTY).

Prior Authorization

Most covered services must be approved before you can get them. This is called "prior authorization." If your provider thinks you need a service, they'll ask us for prior authorization. Our highly qualified staff makes decisions about the care and services you need. These decisions are based on three things:

- Your service needs
- National guidelines
- Information from your provider

If you're new to CountyCare, we'll honor prior authorizations of services from Medicaid or another health plan for 90 calendar days after you join. Call Member Services at 1-312-864-8200 or 1-855-444-1661 (toll-free) / 711 (TDD/TTY) if you have questions about prior authorizations.

Prior Authorization Steps

- Your care coordinator will work with you to develop your care or service plan. All services in the plan given to you by your care coordinator are authorized.

–OR–

- Your provider contacts us by phone, fax or email to ask for prior authorization. They tell us about the service and why you need it.
- Our staff looks at the information to decide if the service can be approved. They may talk more with your provider

Managed Long-Term Services & Supports (MLTSS) Covered Services

MLTSS is a program for members who have full Medicaid and Medicare benefits, live in a nursing facility or receive HCBS waiver services.

MLTSS Covered Services include:

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

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

CountyCare operates five Home and Community-Based Services (HCBS) waiver programs through the Illinois Department of Health Care and Family Services for individuals who qualify. Some limitations and prior authorization requirements may apply.

A waiver program provides services that allow individuals to remain in their own homes or live in a community setting, instead of living in an institution or a nursing facility. These HCBS waiver services are available in addition to behavioral health and transportation 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. Following the assessment, an overall DON score is given, which will determine your eligibility.

The five HCBS Waiver Programs currently operated by CountyCare include:

WAIVERS
Aging Waiver For people age 60 or older and at risk of nursing facility placement.
Persons with Disabilities Waiver For people who 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 age 65 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 for your home
- Home health aide
- Intermittent nursing services
- Skilled nursing - registered nurse (RN) and licensed practical nurse (LPN)
- Occupational therapy
- Physical therapy
- Speech therapy
- Homemaker
- Home-delivered meals

- Individual provider/personal assistant
- Respite
- Specialized medical equipment and supplies
- Personal Emergency Response System (PERS)

Division of Rehabilitation Services (DRS)

People with brain injuries:

- Adult day service
- Adult day service transportation
- Environmental accessibility adaptations for your home
- Home health aide
- Intermittent nursing services
- Skilled nursing - registered nurse (RN) and licensed practical nurse (LPN)
- Occupational therapy
- Physical therapy
- Speech therapy
- Homemaker
- Home-delivered meals
- Individual provider/personal assistant
- Respite
- Specialized medical equipment and supplies
- Pre-vocational services
- Rehabilitation day services
- Personal Emergency Response System (PERS)
- Behavioral services - Masters (MA) and Doctor of Medicine (MD)
- Respite

Healthcare and Family Services (HFS)

Supportive living facility:

- Apartment-style living
- Ancillary services
- Health promotion and exercise
- Housekeeping
- Laundry
- Maintenance
- Medication oversight
- Intermittent nursing services
- Personal care
- Social and recreational programming
- 24-hour response/security
- Meals and snacks

New Technology

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

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

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

Long-Term Care (LTC)

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

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

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

Behavioral Health and Substance Use Services

If you have a life-threatening emergency, please call 9-1-1 or go to the nearest hospital emergency department.

CountyCare, through our large network of providers, offers behavioral health services to treat mental health and substance use disorders. Behavioral health services are available for children and adult CountyCare members. We want to help you stay healthy in mind as well as body. To access these services, please call Member Services at 312-864-8200/ 855-444-1661 (toll-free) / 711 (TDD/TTY). Services are available at outpatient, inpatient, and residential levels depending on the need of the member.

Our network of providers offer treatment for:

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

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

- Medication-assisted treatment for substance use disorder like methadone, suboxone and naltrexone
- Crisis stabilization services
- Medication management
- Mental health assessments
- Case management
- Individual, group and family therapy
- Psychological testing
- Community support
- Partial hospitalization
- Inpatient psychiatric care
- Electroconvulsive therapy (ECT)
- Withdrawal management

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- Residential rehabilitation

If you need these services, speak with your 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 and families in Illinois. CountyCare members can use the 24-hour Crisis and Referral Entry Services (CARES) line to talk to a behavioral health professional. You can call if you or your child is a risk to themselves or others, having a mental health crisis or if you would like a referral to services. Call the CARES line at 1-800-345-9049 (TTY: 1-773-523-4504).

Transportation Services

CountyCare provides transportation to and from appointments for covered services.

If you need a ride please call Member Services at 312-864-8200 /855-444-1661 (toll-free) / 711 (TDD/TTY) or check our **website** for additional ways to schedule a ride. You need to set up a ride at least three days before your visit.

If you need a family member or personal care attendant to ride with you, they can at no cost to you.

If you have a medical emergency, dial 9-1-1. Use of emergency transportation must be for emergencies only and will be paid for by your health plan covering your Medicare benefits.

You can call CountyCare Member Services at 312-864-8200, 711 (TTY/TDD) with any questions.

You can also contact the Bureau of Professional and Ancillary Services at 877-782-5565 for fee-for-service issues.

CountyCare Member Extra Benefits

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

CountyCare Rewards Card

What is it?

The CountyCare Rewards Card Program lets you earn cash rewards to pay for what you need, such as groceries, transportation, utilities and more at most places that accept Visa.

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 to pay for what you need from most places that accept Visa. Your card can't be used to buy alcohol, tobacco, or firearm products.

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, immediately call CountyCare Member Services to close the card and have a new one sent and report any missing or stolen funds. There is no guarantee that Visa will return any missing or stolen funds.

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.

Annual Health Risk Screening - $15 reward

When you complete your annual health risk screening, CountyCare will give you a $15 credit on your reward card. Call Member Services to be connected with your care coordinator to complete the screening.

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.

Additional CountyCare Benefits

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 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., Saturday 9 a.m. to 1 p.m., or visit our website for more information

Care Management Member Rights and Responsibilities

Care Management Program Participation for HCBS Members – MLTSS

Members enrolled in Home and Community Based Services (HCBS) must participate in care management. Failure to participate in home visits and/or provide written consent or acknowledgement will imply non-participation in care management. HCBS members must also adhere to the program rules around cooperation:

- Being present in the home to receive the services
- Notifying the provider in advance of any absences
- Allowing the provider to come into the home to provide the services
- Not interfering with the delivery of services
- Not threatening the provider or care coordinator or acting abusively

HCBS members who do not permit home visits, refuse care coordination, opt out of the program 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 as applicable.

MLTSS Member Rights

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

- Education on their member rights at the time of service initiation, change in service and annually
- The opportunity to choose the types of services they are receiving and their providers
- The right to have input, agree on your care plan, and get a copy of it.
- The right to refuse treatment or services and learn about the implications of such refusal on the member's benefits eligibility and/or health outcomes
- Education on how and to whom to report wrongful death, abuse, neglect and exploitation at the time of the assessment and reassessment
- The use of end-of-life and advance care directives
- The right to receive notification and rationale when care coordination services are changed or terminated
- Alternative approaches when the member and/or family are unable to fully participate in the assessment phase

Advance Directives

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

In Illinois, there are four types of advance directives:

- **Health Care Power of Attorney** - This lets you pick someone to make your health care decisions if you are too sick to decide for yourself. You can print one from the Illinois Department of Public Health website: **https://bit.ly/powerofattorneyhealthcareform**
- **Living Will** - This tells your doctor and other providers what type of care you want if you are terminally ill. "Terminally ill" means your condition will not get better.
- **Mental Health Preference** - This lets you decide if you want to receive some types of mental health treatment that might be able to help you.
- **Do Not Resuscitate/Practitioner Orders for Life-Sustaining Treatment (DNR/POLST) order** - This tells your family, all your doctors and other providers what you want to do in case your heart or breathing stops. It can also be used to write down your wishes for life-sustaining treatment.

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

You can state your medical care wishes in writing while you are healthy and able to make a decision. Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. It also must ask you if you have put your wishes in writing.

No one can make you complete an advance directive. You decide if you want to have an advance directive.

Anyone age 18 or older who is of sound mind and can make his or her own decisions can have an advance directive. You do not need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

Talk to your provider to get an advance directive form. You can also call Member Services or your care coordinator for an advance directive form or help filling it out.

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

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

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

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

To appoint someone to represent you, either:

1. Send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information, or
2. Fill out the authorized representative form. You may find this form on our website at **https://bit.ly/ccauthorizedrepresentative**

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

Appeals

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

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

You may appeal within **60 calendar days** of the date on our adverse benefit determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **10 calendar days** from the date on our adverse benefit determination letter. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that had previously been approved
- Not giving you the service or items in a timely manner

- Not advising you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

Here are two ways to file an appeal:

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

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

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

Can someone help you with the appeal process?

You have several options for assistance. You may:

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

To appoint someone to represent you, either:

1. Send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information, or
2. Fill out the authorized representative form. You may find this form on our website at **https://bit.ly/ccauthorizedrepresentative**

Appeal Process

We will send you an acknowledgement letter within three business days saying we received your appeal. We will tell you if we need more information and how to give us 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 to you in writing within 15 business days of the date we received your appeal request. CountyCare may request an extension up to 14 more calendar days to make a decision on your case if we need more information. You can also ask us for an extension if you need more time to obtain additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Decision Notice.

The Decision Notice will tell you what we will do and why.

If CountyCare's decision agrees with the adverse benefit determination, you may have to pay for the cost of the services you 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 have the option to be there when CountyCare reviews your appeal.

How can you expedite your appeal?

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

How can you withdraw an appeal?

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

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

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

What happens next?

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

State Fair Hearing

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

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- Visit **https://abe.illinois.gov/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.
- 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 Street, 4th Floor
Chicago, IL 60602
Fax: 312-793-2005
Email: HFS.FairHearings@illinois.gov

- You may also call 855-418-4421 / TTY: 800-526-5812
- If you want to file a State Fair Hearing Appeal related to mental health services or items, substance use services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services or any Home Services Program (HSP) service, send your request in writing to:

Illinois Department of Human Services Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602
Fax: 312-793-8573
Email: DHS.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 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 accommodations you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

Continuance or Postponement

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

Failure to Appear at the Hearing

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

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

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

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

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

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

The State Fair Hearing Decision

A final administrative decision will be sent to you and all interested parties in writing by the appropriate hearings office. The decision will also be available online through your ABE appeals account. This final administrative decision is reviewable only through the Illinois circuit courts. The time the circuit court will allow for filing of such review may be as short as 35 days from the date of this letter. If you have questions, please call the hearings 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
- Not know you and will not know your identity during the review

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

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

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

What Happens Next?

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

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

Expedited external review

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

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

What Happens Next?

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

Rights & Responsibilities

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

Member Rights:

- Be treated with respect and dignity at all times.
- Have your personal health information and medical records kept private, except where allowed by law.
- Be protected from discrimination.
- Be free from any form of restraint or seclusion used as a way to force or control or ease reprisal or retaliation.
- Receive information, including the member handbook, from CountyCare in other languages or formats, such as audio, large print or Braille.
- Have an interpreter available when needed.
- Have a candid discussion with your provider about appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Receive information on available treatment options and alternatives. This includes the right to ask for a second opinion. Providers must explain your treatment options in a way you understand.
- Receive the necessary information to make decisions about your health care treatment.
- Refuse treatment and be told what may happen to your health if you do so.
- Receive a copy of your medical records and, in some cases, request that they be amended or corrected.
- File a complaint (sometimes called a "grievance") 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 and receive, in a reasonable amount of time, information about CountyCare Health Plan and its providers, services and polices.
- Receive information about CountyCare member rights and responsibilities. You also have the right to suggest changes to this policy.
- Receive health care services in ways that comply with federal and state law. CountyCare must make covered services accessible to you. Services must be available 24 hours a day, seven days a week.

Member Responsibilities:

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

Provider Qualifications and Doctor Incentives

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

- Education
- Board certification
- Recertification

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

Fraud, Waste and Abuse

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

Let us know if you think a health care provider or a person receiving benefits is doing something wrong.

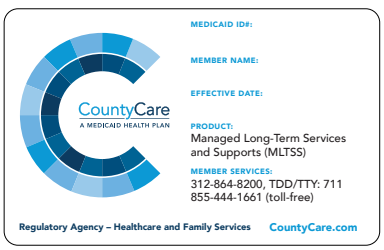
Doing something wrong could be fraud, waste or abuse, which is against the law.

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

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

Tell us if you think someone is:

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



- Not telling the truth about the amount of money or resources they have to get benefits.

CountyCare will send you letters from time to time and ask you to confirm that you received medical 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 Critical 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 for the physical safety of an individual

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

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

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

Critical Incident Reporting Requirements

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

How to Report a Critical Incident

Incidents related to CountyCare members can be reported to CountyCare 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 critical incidents to the appropriate state agency, as follows:

- **For members age 18-59 with a disability or age 60 or 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

  Telephone Number: **800-252-2873 (voice) TTY: 800-358-5117.**

- **For members in nursing facilities:**

  Department of Public Health Nursing Home Complaint

  Hotline Telephone Number: **800-252-4343**

- **For members age 18-59 receiving mental health or developmental disability services in DHS-operated, licensed, certified or funded programs:**

  Illinois Department of Human Services Office of the Inspector

  General Telephone Number: **800-368-1463 (voice and TTY)**

- **For members in supportive living facilities:**

  Department of Healthcare and Family Services SLF

  Complaint Hotline Telephone Number: **800-226-0768**

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

Physical abuse signs to look for:

- Punching, hitting, beating
- Slapping, smacking

- Pushing, shoving, shaking
- Pinching, cutting, slicing
- Improperly physically restraining

Sexual abuse signs to look for:

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

Emotional abuse signs to look for:

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

Neglect signs to look for:

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

Financial abuse signs to look for:

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

Definitions

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

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

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

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

Emergency 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: **HealthTrio connect - connect Login**

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