2017

Medicaid Managed Care Grievance Procedures

CONTENTS

Aetna Better Health…… 2

Blue Cross Blue Shield of Illinois…… 10

Cigna HealthSpring…….. 17

Community Care Alliance…… 26

County Care…….. 34

Family Health Network…… 42

Harmony…… 49

Humana…….. 57

Illinicare…… 65

Illinois Health Connect…… 72

Meridian…… 74

Molina Healthcare…… 81

NextLevel Health…….. 89

AETNA BETTER HEALTH

Grievances and Appeals

We want you to be happy with services you get from Aetna Better Health of Illinois and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

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

Aetna Better Health of Illinois 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. Aetna Better Health of Illinois 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.

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

- Your provider or an Aetna Better Health of Illinois 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 an Aetna Better Health of Illinois staff member was rude to you.
- Your provider or an Aetna Better Health of Illinois staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Member Services at 866-212-2851. You can also file your grievance in writing via mail or fax at:

Aetna Better Health
Attn: Grievance and Appeals Dept.
333 West Wacker Drive, Mail Stop F646
Chicago, Il 60606
Fax: 1-855-545-5196

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at 866-212-2851.

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Aetna Better Health of Illinois in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, it will go to our Grievance Committee. We may contact you for more information. The Grievance Committee will make a recommendation within sixty (60) calendar days from the date you filed your grievance. You will get a letter from Aetna Better Health of Illinois with our resolution.

Appeals

You may not agree with a decision or an action made by Aetna Better Health of Illinois about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal.

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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

Here are two ways to file an appeal.

1) Call Member Services at 866-212-2851. 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:

Aetna Better Health
Attn: Grievance and Appeals Dept.
One South Wacker Drive, Mail Stop F646
Chicago, Il 60606
Fax: 1-855-545-5196

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.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at 1-800-641-3929 (Voice) or 1-888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at: www.aetnabetterhealth.com/illinois.

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

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

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

If Aetna Better Health of Illinois Family Health Plan's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Aetna

Better Health of Illinois Family Health Plan's decision does not agree with the Notice of Action, 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 Aetna Better Health of Illinois reviews your appeal.

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Aetna Better Health of Illinois 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 Aetna Better Health of Illinois at 866-212-2851.

What happens next?

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

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within **thirty (30) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If

you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Aetna Better Health of Illinois Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you.

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.

- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

  Illinois Department of
  Healthcare and Family Services
  Bureau of Administrative Hearings
  401 S Clinton Street, 6th Floor
  Chicago, IL 60607
  Fax: (312) 793-2005

  Or you may call (855) 418-4421, TTY: (800) 526-5812

- If you want to file a State Fair Hearing Appeal related to 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
  401 S Clinton Street, 6th Floor
  Chicago, IL 60607
  Fax: (312) 793-8573

  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.

At least three (3) business days before the hearing, you will receive information from Aetna Better Health of Illinois Family Health Plan. 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 Aetna Better Health of Illinois and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the

Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

External Review (for medical services only)

Within **thirty (30) calendar days** after the date on the Aetna Better Health of Illinois appeal Decision Notice, you may choose to ask for a review by someone outside of Aetna Better Health of Illinois Family Health Plan. This is called an external review. The outside reviewer must meet the following requirements:

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

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

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

Aetna Better Health
Attn: Grievance and Appeals Dept.
One South Wacker Drive, Mail Stop F646
Chicago, Il 60606
Fax: 1-855-545-5196

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Aetna Better Health of Illinois a letter with their decision within five (5) 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 866-212-2851. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Aetna Better Health
Attn: Grievance and Appeals Dept.
One South Wacker Drive, Mail Stop F646
Chicago, Il 60606

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Aetna Better Health of Illinois know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Aetna Better Health of Illinois with the decision within forty-eight (48) hours.

BLUE CROSS BLUE SHIELD

APPEALS AND GRIEVANCES

At Blue Cross and Blue Shield of Illinois (BCSBIL), we take great pride in ensuring that you receive the care you need. But if you have a complaint about how we handle any services provided to you, you can file a grievance or an appeal.

GRIEVANCE (COMPLAINT)

A grievance is a complaint about any matter besides a service that has been denied, reduced or ended.

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

You may want to file a grievance if:

- Your provider or a BCBSIL employee did not respect your rights
- You had trouble getting an appointment with your provider in an reasonable amount of time
- You were unhappy with the care or treatment you received
- Your provider or a BCBSIL employee was rude to you
- Your provider or a BCBSIL employee did not respect your cultural needs or other special needs you may have

APPEALS

An appeal is a way for you to ask for someone to review our actions. You might want to file an appeal if BCBSIL:

- Does not approve a service your provider asks for
- Stops a service that was approved before
- Does not pay for a service your PCP or other provider asked for
- Does not give you the service in a timely manner
- Does not answer your appeal in a timely manner
- Does not approve a service for you because it was not in our network

If BCBSIL decides that a requested service cannot be approved, or if a service is reduced, stopped or ended, you will get a "Notice of Action" letter from us. You must file your appeal within 60 calendar days from the date on the Notice of Action letter.

HOW TO FILE AN APPEAL OR GRIEVANCE

At any time during the appeals process, you can have someone you know represent you or act on your behalf. This person will be your "representative." Fill out the Authorized Representative Designation Form and fax or email to us.

There are two ways to file an appeal or grievance (complaint):

- Call Member Services at 1-877-860-2837. If you do not speak English, we can provide an interpreter at no cost to you. If you are hearing impaired, call the Illinois Relay at 711.

- Write to us at:

  Blue Cross Blue Shield of Illinois
  Attn: Grievance and Appeals Unit
  P.O. Box 27838
  Albuquerque, NM 87125-9705
  Fax: 1-866-643-7069

APPEAL PROCESS

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

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

We will call 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 BCBS-IL's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If BCBS-IL's decision does not agree with the Notice of Action, 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 BCBS-IL reviews your appeal.

HOW CAN YOU EXPEDITE YOUR APPEAL?

If you or your provider believes our standard timeframe of 15 business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action 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 the Decision Notice to you and your authorized representative.

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 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.
BCBS-IL 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 BCBS-IL at 1-888-657-1211

WHAT HAPPENS NEXT?

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

STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within 30 calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within 10 calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for the services provided to you during the appeal process. At the State Fair Hearing, just like during the BCBS-IL Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

Illinois Department of Healthcare and Family Services

Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: (312) 793-2005
Email: HFS.FairHearings@illinois.gov

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

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

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: (312) 793-8573

Email:DHS.HSPAppeals@illinois.gov

Or you may call 800-435-0774
TTY: 877-734-7429

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. At least three business days before the hearing, you will receive information from BCBS-IL. 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 BCBS-IL and the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

CONTINUANCE OR POSTPONEMENT

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A
Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within 10 calendar days from the date you received the Dismissal Notice, 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as 35 days from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW (FOR MEDICAL SERVICES ONLY)

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

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

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

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

Blue Cross Blue Shield of Illinois
Attn: Grievance and Appeals Unit
P.O. Box 27838
Albuquerque, NM 87125-9705
Fax: 1-866-643-7069

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 BCBS-IL 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 1-888-657-1211 TTY/TDD 711. 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.

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

Blue Cross Blue Shield of Illinois
Attn: Grievance and Appeals Unit
P.O. Box 27838
Albuquerque, NM 87125-9705
Fax: 1-866-643-7069

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 BCBS-IL know what their decision is verbally. They will also follow up with a letter to you and/or your representative and BCBS-IL with the decision within 48 hours.

CIGNA HEALTH SPRING

GRIEVANCES AND APPEALS

We want you to be happy with services you get from Cigna-HealthSpring SpecialCare of Illinois and our providers. If you are not happy, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item. Cigna-HealthSpring SpecialCare of Illinois 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. Cigna-HealthSpring SpecialCare of Illinois 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.

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

- Your provider or a Cigna-HealthSpring SpecialCare of Illinois 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 Cigna-HealthSpring SpecialCare of Illinois staff member was rude to you.
- Your provider or a Cigna-HealthSpring SpecialCare of Illinois 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 Customer Service at (866) 487-4331.

You can also file your grievance in writing via mail or fax at:

Cigna-HealthSpring SpecialCare of Illinois
Attn: Grievance and Appeals Dept.
175 W. Jackson St. Suite 1750
Chicago, IL, 60604
Fax: (877) 788-2830

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what

happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Customer Service at (866) 487-4331.

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Cigna-HealthSpring SpecialCare of Illinois in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

Appeals

You may not agree with a decision or an action made by Cigna-HealthSpring SpecialCare of Illinois about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal.

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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

Here are two ways to file an appeal.

1) Call Customer Service at (866) 487-4331. 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:

Cigna-HealthSpring SpecialCare of Illinois
Attn: Appeals Resolution Center
PO Box 24087
Nashville, TN 37202
Fax: (855) 320-4409

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.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at 1-800-641-3929 (Voice) or 1-888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at http://www.specialcareil.com/resources

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.
A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

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

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

If Cigna-HealthSpring SpecialCare of Illinois' decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Cigna-HealthSpring SpecialCare of Illinois' decision does not agree with the Notice of Action, 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 Cigna-HealthSpring SpecialCare of Illinois reviews your appeal.

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Cigna-HealthSpring SpecialCare of Illinois 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 Cigna-HealthSpring SpecialCare of Illinois at 1-866-487-4331.

What happens next?

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

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within **thirty (30) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If

you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process. At the State Fair Hearing, just like during the Cigna-HealthSpring SpecialCare of Illinois Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

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

  Or you may call (855) 418-4421, TTY: (800) 526-5812

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

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

Or you may call (800) 435-0774, TTY: (877) 734-7429

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. At least three (3) business days before the hearing, you will receive information Cigna-HealthSpring SpecialCare of Illinois. 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 Cigna-HealthSpring

SpecialCare of Illinois and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

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

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

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

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

Cigna-HealthSpring SpecialCare of Illinois
Attn: External Review Center
PO Box 24087
Nashville, TN 37202
Fax: (855) 320-4409

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer. The external reviewer will send you and/or your representative and Cigna-HealthSpring SpecialCare of Illinois a letter with their decision within five (5) 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 (866) 487-4331. To ask in writing, send us a letter at the address below.

You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Cigna-HealthSpring SpecialCare of Illinois
Attn: Expedited External Review Center
PO Box 24087
Nashville, TN 37202

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer.
- We will also send the necessary information to the external reviewer so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Cigna-HealthSpring SpecialCare of Illinois know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Cigna-HealthSpring SpecialCare of Illinois with the decision within forty-eight (48) hours.

Report Fraud, Waste and Abuse

Health care fraud is a violation of federal and/or state law. If you know of or suspect health insurance fraud, please report it by calling our Compliance and Ethics Hotline at (800) 826-6762. You are not required to identify yourself when you report the information. The hotline is anonymous.

Reporting Abuse, Neglect, Exploitation or Unusual Incidents

You can contact the Department of Public Health to get information on CNAs or the Department of Financial and Professional Regulation for information on any LPN or RN that you want to employ to see if they have claims of abuse, neglect or theft. If you are the victim of abuse, neglect or exploitation, you should report this to your care coordinator right away.

You should also report the issue to one of the following agencies based on your age or placement. All reports to these agencies are kept private and anonymous reports are accepted. For more information, please call Customer Service at (866) 487-4331.

Nursing Home Hotline– (800) 252-4343

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

Office of the Inspector General– (800) 368-1463

The Illinois Department of Human Services Office of Inspector General Hotline is to report allegations of abuse, neglect or exploitation for people 18 to 59 years old.

Aging/Elder Abuse – (866) 800-1409 (TTY (888) 206-1327)

The Illinois Department on Aging Elder Abuse Hotline is to report allegations of abuse, neglect or exploitation for people 60 years old and over. Your care coordinator will give you 2 brochures on reporting Elder Abuse and Exploitation. You can request new copies of these brochures at any time.

Illinois law defines abuse, neglect and exploitation as:

- **Physical abuse —** inflicting physical pain or injury upon a senior or person with disabilities.
- **Sexual abuse —** touching, fondling, intercourse or any other sexual activity with a senior or person with disabilities, when the person is unable to understand, unwilling to consent, threatened or physically forced.
- **Emotional abuse —** verbal assaults, threats of abuse, harassment or intimidation.
- **Confinement —** restraining or isolating the person, other than for medical reasons.
- **Passive neglect —** the caregiver's failure to provide a senior or person with disabilities with life's necessities, including, but not limited to, food, clothing, shelter or medical care.
- **Willful deprivation —** willfully denying a senior or person with disabilities medication, medical care, shelter, food, a therapeutic device or other physical assistance, and thereby exposing that adult to the risk of physical, mental or emotional harm — except when the person has expressed an intent to forego such care.
- **Financial exploitation —** the misuse or withholding of a senior or person with disabilities' resources to the disadvantage of the person or the profit or advantage of someone else.

COMMUNITY CARE ALLIANCE

Grievances and Appeals

We want you to be happy with the services you get from CCAI and our providers. If you are not happy, you have the right to file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced, or terminated service or item. CCAI 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. CCAI has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to take care of your concern. Filing a grievance will not affect your health care services or benefits coverage.

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

- Your provider or a CCAI 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 CCAI staff member was rude to you.
- Your provider or a CCAI staff member was insensitive to your cultural needs or other special needs you may have.

You can file a grievance on the phone by calling CCAI at 1-866-871-2305 (TTY 711). You can also file your grievance in writing by mail or by fax at:

Community Care Alliance of Illinois
Attn: Grievance and Appeals Unit
322 S. Green St, Suite 400, Chicago, IL 60607
Fax: 1-312-257-2069

In the grievance letter, give us as much information as you can. For example, include the date and place the problem happened. Also, tell us the names of the people involved. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling 1-866-871-2305 (TTY 711).

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, fill out the Authorized Representative Form for Grievance and Appeals listed at www.ccaillinois.com.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information. We will take action on your grievance no later than 90 days after receiving it. And we will send you and your authorized representative a Grievance Decision Notice to tell you what we did to resolve your issue and the reasons why.

Appeals

You may not agree with a decision or an action made by CCAI about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **60 calendar days** of the date on our Notice of Action 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 Notice of Action letter. Here are examples of when you might want to file an appeal:

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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 an External Independent Review and/or 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. It will also tell you how to do it, and when you may have to pay for the services

Here are two ways to file an appeal:

1) Call Member Services at 1-866-871-2305 and ask to talk to the Appeals unit. 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:

Community Care Alliance of Illinois
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400, Chicago, IL 60607
Fax: 1-312-257-2069

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 Appeals Process?

You have several options for assistance. You may:

- Ask someone you know to help in representing you. For example, this could be your primary care physician or a family member.
- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also call Client Assistance Program (CAP) for help at 1-800-641-3929 (voice) or 1-888-460-5111 (TTY).

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 for Grievances and Appeals form. You may find this form on the CCAI website at www.ccaillinois.com.

Appeal Process

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

CCAI will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. CCAI may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to get more 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 CCAI's decision agrees with the Notice of Action, you may have to pay for the cost of the

services you got during the appeal review. If CCAI's decision does not agree with the Notice of Action, 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 CCAI reviews your appeal.

How can you expedite your Appeal?

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

CCAI will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need more information about withdrawing your appeal, call CCAI at 1-866-871-2305.

What happens next?

After you receive the CCAI 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 within **thirty (30) calendar days** of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within thirty **(30) calendar days of the date** on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten **(10) calendar days of the date** on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the CCAI Appeals process, you may ask for someone to represent you, such as a lawyer, or have a relative or friend speak for you. To appoint someone to represent you, you can send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information. You can also use the Authorized Representative for Grievances and Appeals found on our website at www.ccaillinois.com.

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.

- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program, or CCP) services, send your request in writing to:

  Illinois Department of Healthcare and Family Services
  Bureau of Administrative Hearings
  69 W. Washington Street, 4th Floor, Chicago, IL 60602
  Fax: 1-312-793-2005, Email: HFS.FairHearings@illinois.gov
  Or you may call 1-855-418-4421, TTY: 1-800-526-5812

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

  Illinois Department of Human Services
  Bureau of Hearings
  69 W. Washington Street, 4th Floor, Chicago, IL 60602
  Fax: 1-312-793-8573, Email: DHS.HSPAppeals@illinois.gov
  Or you may call 1-800-435-0774, TTY: 1-877-734-7429

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.

At least three (3) business days before the hearing, you will receive information from CCAI. 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 evidence you will present at the hearing to CCAI and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date, and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

- A death in the family
- Personal injury or illness that 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of the Final Administrative Decision. If you have questions, please call the Hearing Office.

External Review

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

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

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

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

Community Care Alliance of Illinois
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400, Chicago, IL 60607
Fax: 1-312-257-2069

What Happens Next?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and CCAI a letter with their decision within five (5) 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 1-866-871-2305. To ask in writing, send your request via mail or fax to the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Community Care Alliance of Illinois
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400
Chicago, IL 60607
Fax: 1-312-257-2069

What Happens Next?

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

- We will also send the necessary information to the external reviewer so they can begin their review.

- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and CCAI know what their decision is verbally. They will also follow up with a letter to you and/or your representative and CCAI with the decision within forty-eight (48) hours.

COUNTY CARE

Grievances and Appeals

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

GRIEVANCES

A grievance is a complaint about any matter other than a denied, reduced, or terminated service or item. 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 healthcare services or your benefits coverage.

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 at:

CountyCare
Attn: Grievance and Appeals Dept.
PO Box 803758
Chicago, IL 60680
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 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." If you decide to have someone represent you or act for you, inform CountyCare in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. You will get a letter from CountyCare with our resolution.

APPEALS

You may not agree with a decision or an action made by CountyCare about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within 60 calendar days of the date on our Notice of Action form. 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 Notice of Action form. The list below includes examples of when you might want to file an appeal.

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a Notice of Action 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

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
Grievance and Appeals Coordinator
PO Box 803758
Chicago, IL 60680
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 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
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact Client Assistance Program (CAP) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.countycare.com.

APPEAL PROCESS

We will send you an acknowledgment letter within three business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

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

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

If CountyCare's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If CountyCare's decision does not agree with the

Notice of Action, we will approve the services to start right away.

Things to keep in mind during the appeal process:

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

HOW CAN YOU EXPEDITE YOUR APPEAL?

If you or your provider believes our standard time frame of 15 business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, and 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 used to file 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 fi e 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 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 30 calendar days of the date

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

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.
• If you want to file a State Fair Hearing appeal related to your medical services or items, or
Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

Illinois Department of Healthcare and Family Services
69 W. Washington, 4th Floor
Chicago, Illinois 60602
Fax: 312-793-2005
Or you may call 855-418-4421 /
800-526-5812 (TTY).

• If you want to file a State Fair Hearing appeal related to 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, 4th Floor
Chicago, Illinois 60602
Fax: 312-793-8573
Or you may call 800-435-0774 /
877-734-7429 (TTY).

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 Officer 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.

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

CONTINUANCE OR POSTPONEMENT

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date, and place on the notice and you have not requested a 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 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 Officer 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 Officer This final administrative decision is reviewable only through the Circuit Courts of the state of Illinois. The time the Circuit Court will allow for the final of such review may be as short as 35 days from the date of this letter. If you have questions, please call the Hearing Officer.

EXTERNAL REVIEW (FOR MEDICAL SERVICES ONLY)

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

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

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

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

CountyCare
Grievance and Appeals Coordinator
PO Box 803758
Chicago, IL 60680
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 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 date on 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 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 specification. Your letter must ask for an external review of that action.

CountyCare
Grievance and Appeals Coordinator
PO Box 803758
Chicago, IL 60680

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.

• The external reviewer will make a decision about your request as quickly as your health condition requires, but no more than two business days after receiving all information needed. 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.

FAMILY HEALTH NETWORK

Grievances and Appeals

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

GRIEVANCES

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item. FHN 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. FHN has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to take care of your concern. Filing a grievance will not affect your health care services or your benefits coverage. If you are not satisfied with the resolution of your grievance, you may appeal a decision that affects your coverage, benefits, or relationship with FHN.

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

- Your provider or an FHN 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 an FHN staff member was rude to you.
- Your provider or an FHN 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 FHN at 1-888-346-4968. You can also file your grievance in writing by mail or by fax at:

Family Health Network
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400, Chicago, IL 60607
Fax: 1-312-257-2060

In the grievance letter, give us as much information as you can. For example, include the date and place the problem happened. Also, tell us 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 1-888-346-4968.

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be “your representative.” If you decide to have someone represent you or act for you, inform FHN in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

APPEALS

You may not agree with a decision or an action made by FHN about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within 60 calendar days of the date on our Notice of Action form. 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 Notice of Action form. Here are examples of when you might want to file an appeal:

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a Notice of Action 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. It will also tell you how to do it, and when you may have to pay for the services

Here are two ways to file an appeal.

1. Call Member Services at 1-888-346-4968 and ask to talk to the Appeals Unit. 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:

Family Health Network
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400, Chicago, IL 60607
Fax: 1-312-257-2060

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
• If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact Client Assistance Program (CAP) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.fhnchicago.com

APPEAL PROCESS

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

FHN will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. FHN may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension if you need more time to get more 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 FHN's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If FHN's decision does not agree with the Notice of Action, 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 FHN reviews your appeal.

HOW CAN YOU EXPEDITE YOUR APPEAL?

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

FHN 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 FHN at 1-888-346-4968

WHAT HAPPENS NEXT?

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

STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly waiver (CCP, or 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: 1-312-793-2005
Email: HFS.FairHearings@illinois.gov

Or you may call 1-855-418-4421, TTY: 1-800-526-5812

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

Illinois Department of Human Services Bureau of Hearings
69 W. Washington Street, 4th Floor, Chicago, IL 60602
Fax: 1-312-793-8573
Email: DHS.HSPAppeals@illinois.gov

Or you may call 1-800-435-0774, TTY: 1-877-734-7429

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.

At least three (3) business days before the hearing, you will receive information from FHN. 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 FHN and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

CONTINUANCE OR POSTPONEMENT

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

- A death in the family
- Personal injury or illness that 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW

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

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

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

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

Family Health Network
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400 Chicago, IL 60607
Fax: 1-312-257-2060

WHAT HAPPENS NEXT?

- We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

- You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer

The external reviewer will send you and/or your representative and FHN a letter with their decision within five (5) 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 1-888-346-4968. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Family Health Network
Attn: Grievance and Appeals Unit
322 S. Green Street, Suite 400 Chicago, IL 60607
Fax: 1-312-257-2060

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 he/she can begin his/her review.

• As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/ or your representative and FHN know what his/her decision is verbally. They will also follow-up with a letter to you and/or your representative and FHN with the decision within forty-eight (48) hours.

HARMONY HEALTH PLAN

Grievances and Appeals

We want you to be happy with services you get from Harmony Health Plan and our providers. If you are not happy, you can file a grievance or appeal.

GRIEVANCES

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

Harmony 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. Harmony 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.

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

- Your provider or a Harmony 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 Harmony staff member was rude to you.
- Your provider or a Harmony 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 Harmony at 1-800-608-8158. You can also file your grievance in writing via mail or fax at:

Harmony Health Plan
Attn: Grievance Department
P.O Box 31384
Tampa, FL 33631-3384
Fax: 1-866-388-1769

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at 1-800-608-8158.

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.

We will mail you a letter acknowledging receipt within 10 business days of receiving your grievance.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your representative. If you decide to have someone represent you or act for you, inform Harmony in writing of the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information. We will mail you a letter with a resolution within 60 calendar days of receiving your grievance.

APPEALS

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

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a Notice of Action 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. It will also tell you how to do it, and when you may have to pay for the services

Here are two ways to file an appeal.

1. Call Member Services at 1-800-608-8158. 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:

Harmony Health Plan
Attn: Appeals Department
P.O Box 31368
Tampa, FL 33631-3368
Fax: 1-866-201-0657

Harmony Health Plan
Attn: Pharmacy Medication
Appeals Department
P.O Box 31398

Tampa, FL 33631-3398
Fax: 1-888-865-6531

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
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact Client Assistance Program (CAP) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.harmonyhpi.com

APPEAL PROCESS

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

Harmony will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Harmony may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension if you need more time to get more 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 Harmony's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Harmony's decision does not agree with the Notice of Action, 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 Harmony reviews your appeal.

HOW CAN YOU EXPEDITE YOUR APPEAL?

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

Harmony 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 Harmony at 1-800-608-8158

WHAT HAPPENS NEXT?

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

STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.

• If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly waiver (CCP, or 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: 1-312-793-2005

Email: HFS.FairHearings@illinois.gov

Or you may call 1-855-418-4421, TTY: 1-800-526-5812

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

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: 1-312-793-8573

Email: DHS.HSPAppeals@illinois.gov

Or you may call 1-800-435-0774, TTY: 1-877-734-7429

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.

At least three (3) business days before the hearing, you will receive information from Harmony. 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 Harmony and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

CONTINUANCE OR POSTPONEMENT

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

- A death in the family
- Personal injury or illness that 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW (for medical services only)

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

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

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

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

Harmony Health Plan
Attn: Appeals Department
P.O Box 31368
Tampa, FL 33631-3368

WHAT HAPPENS NEXT?

• We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

• You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer

The external reviewer will send you and/or your representative and Harmony a letter with their decision within five (5) 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 1-800-608-8158. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Harmony Health Plan
Attn: Appeals Department
P.O Box 31368
Tampa, FL 33631-3368

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 he/she can begin his/her review.

• As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/ or your representative and Harmony know what his/her decision is verbally. They will also follow-up with a letter to you and/or your representative and Harmony with the decision within forty-eight (48) hours.

HUMANA

Grievances and Appeals

We want you to be happy with services you get from Humana Integrated Care Program of Illinois and our providers. If you are not happy, you can file a grievance or appeal.

GRIEVANCES

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

Humana Integrated Care Program of Illinois 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. Humana Integrated Care Program of Illinois 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.

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

- Your provider or a Humana Integrated Care Program of Illinois 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 Humana Integrated Care Program of Illinois staff member was rude to you.
- Your provider or a Humana Integrated Care Program of Illinois 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 Humana Integrated Care Program of Illinois at 1-800-764-7591. You can also file your grievance in writing via mail or fax at:

Humana Integrated Care Program of Illinois Health Plan
Attn: Grievance and Appeals Dept
P.O Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591 for assistance.

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Humana Integrated Care Program of Illinois in writing of the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

APPEALS

You may not agree with a decision or an action made by Humana Integrated Care Program of Illinois about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal.

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a Notice of Action 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. It will also tell you how to do it, and when you may have to pay for the services

Here are two ways to file an appeal.

1. Call Member Services at 1-800-764-7591. 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:

Humana Integrated Care Program of Illinois Health Plan
Attn: Grievance and Appeals Dept.
P.O Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220 (for expedited appeals only)

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
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact Client Assistance Program (CAP) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or 2) fill out the Authorized Representative Appeals form. You may find this form on our website at https://www.humana.com/individual-and-family-support/tools/member-forms

APPEAL PROCESS

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

Humana Integrated Care Program of Illinois will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Humana Integrated Care Program of Illinois may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension if you need more time to get more 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 Humana Integrated Care Program of Illinois' decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Humana Integrated Care Program of Illinois's decision does not agree with the Notice of Action, 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 Humana Integrated Care Program of Illinois reviews your appeal.

HOW CAN YOU EXPEDITE YOUR APPEAL?

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

Humana Integrated Care Program of Illinois 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 Humana Integrated Care Program of Illinois Member Services at 1-800-764-7591

WHAT HAPPENS NEXT?

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

STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within **thirty (30) calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **ten (10) calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly waiver (CCP, or 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: 1-312-793-2005

Email: HFS.FairHearings@illinois.gov

Or you may call 1-855-418-4421, TTY: 1-800-526-5812

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

Illinois Department of Human Services Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: 1-312-793-8573

Email: DHS.HSPAppeals@illinois.gov

Or you may call 1-800-435-0774, TTY: 1-877-734-7429

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.

At least three (3) business days before the hearing, you will receive information from Humana Integrated Care Program of Illinois. 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 Humana Integrated Care Program of Illinois and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

CONTINUANCE OR POSTPONEMENT

You may request a continuance during the hearing or a postponement prior to the hearing, which may be

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

- A death in the family
- Personal injury or illness that 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as **thirty-five (35) days** from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW (for medical services only)

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

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

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

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

Humana Integrated Care Program of Illinois Health Plan
Attn: Grievance and Appeals Dept
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

WHAT HAPPENS NEXT?

• We will review your request to see if it meets the qualifications for external review. We have **five (5) business days** to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

• You have **five (5) business days** from the letter we send you to send any additional information about your request to the external reviewer

The external reviewer will send you and/or your representative and Humana Integrated Care Program of Illinois a letter with their decision within five (5) 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 1-800-764-7591. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Humana, Inc.
Attn: Grievance and Appeals Dept
P.O. Box 14546
Lexington, KY 40512-4546
Fax: 1-855-336-6220

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 he/she can begin his/her review.

• As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request.

They will let you and/ or your representative and Humana Integrated Care Program of Illinois know what his/her decision is verbally. They will also follow-up with a letter to you and/or your representative and Humana Integrated Care Program of Illinois with the decision within forty-eight (48) hours.

ILLINICARE

Grievances and Appeals

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

GRIEVANCES

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

IlliniCare Health 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. IlliniCare Health 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.

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

- Your provider or a IlliniCare Health 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 IlliniCare Health staff member was rude to you.
- Your provider or a IlliniCare Health 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 IlliniCare Health at 1-800-608-8158. You can also file your grievance in writing via mail or fax at:

IlliniCare Health
Attn: Grievance and Appeals Dept.
999 Oakmont Plaza Drive, Suite 400
Westmont, IL 60559
Fax: 1-877-668-2076

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at 866-329-4701 (toll-free) / 866-811-2452 (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. If you decide to have someone represent you or act for

you, inform IlliniCare Health in writing of the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

APPEALS

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

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a Notice of Action 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. It will also tell you how to do it, and when you may have to pay for the services

Here are two ways to file an appeal.

1. Call Member Services at 866-329-4701 (tollfree) / 866-811-2452 (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:

IlliniCare Health
Attn: Grievance and Appeals Dept.
999 Oakmont Plaza Drive, Suite 400
Westmont, IL 60559
Fax: 1-877-668-2076

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 866-811-2452 (TDD/TTY).

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
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact Client Assistance Program (CAP) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.illinicare.com

APPEAL PROCESS

We will send you an acknowledgment letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

IlliniCare Health will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. IlliniCare Health may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension if you need more time to get more 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 IlliniCare Health's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If IlliniCare Health's decision does not agree with the Notice of Action, 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 IlliniCare Health reviews your appeal.

HOW CAN YOU EXPEDITE YOUR APPEAL?

If you or your provider believes our standard timeframe of fifteen (15) business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your

Notice of Action letter, information about your case, and why you are asking for the expedited appeal. We will let you know within twenty-four (24) hours if we need more information. Once all information is provided, we will call you within twenty-four (24) hours to inform you of our decision. We 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.

IlliniCare Health 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 IlliniCare Health at 866-329-4701 (toll-free) / 866-811-2452 (TDD/TTY).

WHAT HAPPENS NEXT?

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

STATE FAIR HEARING

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly waiver (CCP, or 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: 1-312-793-2005

Email: HFS.FairHearings@illinois.gov

Or you may call 1-855-418-4421, TTY: 1-800-526-5812

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

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: 1-312-793-8573

Email: DHS.HSPAppeals@illinois.gov

Or you may call 1-800-435-0774, TTY: 1-877-734-7429

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.

At least three (3) business days before the hearing, you will receive information from IlliniCare Health. 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 IlliniCare Health and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

CONTINUANCE OR POSTPONEMENT

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

FAILURE TO APPEAR AT THE HEARING

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice, and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

- A death in the family
- Personal injury or illness that 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. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as thirty-five (35) days from the date of this letter. If you have questions, please call the Hearing Office.

EXTERNAL REVIEW (for medical services only)

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

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

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

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

IlliniCare Health
Attn: Grievance and Appeals Dept.
999 Oakmont Plaza Drive, Suite 400

Westmont, IL 60559
Fax: 1-877-668-2076

WHAT HAPPENS NEXT?

• We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

• You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer

The external reviewer will send you and/or your representative and IlliniCare Health a letter with their decision within five (5) 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 1-800-608-8158. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

IlliniCare Health
Attn: Grievance and Appeals Dept.
999 Oakmont Plaza Drive, Suite 400
Westmont, IL 60559
Fax: 1-877-668-2076

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 he/she can begin his/her review.

• As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/ or your representative and IlliniCare Health know what his/her decision is verbally. They will also follow-up with a letter to you and/or your representative and IlliniCare Health with the decision within forty-eight (48) hours.

ILLINOIS HEALTH CONNECT

Problems and Complaints

Illinois Health Connect wants you to get the best possible service. When something goes wrong or you are not treated well, we want to know.

Step 1

If you have a problem or complaint about your PCP, Illinois Health Connect, or the service you have received, you can call the Illinois Health Connect Helpline at 1-877-912-1999, Monday through Friday, 8:00 a.m. to 6:00 p.m. to report it. If you use a TTY, call 1-866-565-8577. The call is free.

Or, you can put your complaint in writing and mail it to us at:

Automated Health Systems
ATTN: Illinois Health Connect – QA Unit
1375 EastWoodfield Road
Suite 600
Schaumburg, IL 60173-5418

You have to make your complaint **within 60 days** of the day you are not treated well.

Step 2

We will make a record of your complaint. We will have someone not involved with the matter you are complaining about review your complaint and try to find a solution. Your satisfaction is important to us.

Step 3

We take action on all complaints within 30 days of receiving it. If you are not satisfied with the action taken, you may write to:

Illinois Department of Healthcare and Family Services
Bureau of Managed Care
201 South Grand Avenue East, 3rd floor
Springfield, IL 62763

This is called filing a grievance. If you want to file a grievance, be sure to send it within 60 days of the day of your complaint. Someone from HFS will review the matter and follow up with you as quickly as possible.

Appeals and Fair Hearings

An appeal is a complaint you make when you feel an action was wrong. When you appeal an action, you are asking for a fair hearing about it.

A fair hearing is a meeting with a fair hearing officer, someone from HFS, and you. You can talk about your complaint during the fair hearing, and the fair hearing officer will decide what to do.

You can appeal if HFS:

- Denies your application or redetermination
- Stops your benefits (coverage)
- Says that you will start to get fewer benefits
- Changes your co-payments

You can also appeal if you think we made a mistake about any decision. You must make your appeal **within 60 days** of when the action happened.

You may not get a fair hearing if the action happened because of a change in the law.

How to Make an Appeal

To make an appeal and ask for a fair hearing, or to request assistance with the process over the telephone, call 1-800-435-0774. If you use a TTY, call 1-877-734-7429. The call is free. Hours are from 8:30 a.m. to 4:45 p.m., Monday through Friday.

Or you can write a letter. Mail or fax your letter to:

Illinois Department of Healthcare and Family Services
Attn: Illinois Health Connect
401 South Clinton, 6th Floor
Chicago, IL 60607
Fax #: 1-312-793-0095

MERIDIAN

GRIEVANCES AND APPEALS

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

Grievances

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

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

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

You can file your grievance on the phone by calling Member Services at 866-606-3700, Monday – Friday from 8 a.m. – 8 p.m. You can also file your grievance in writing via mail or fax at:

Meridian Health Plan Grievance Coordinator
333 South Wabash Avenue, Suite 2900
Chicago, IL 60604
Fax: 312-980-0444

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at 866-606-3700.

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, including a physician or an attorney. This person will be"your representative." If you decide to have someone represent you or act for you, inform Meridian in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, it will go to our Grievance Committee. We may contact you for more information. The Grievance Committee will make a recommendation within sixty (60) calendar days from the date you filed your grievance. You will get a letter from Meridian with our resolution.

Appeals

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

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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

Here are two ways to file an appeal.

1) Call Member Services at 866-606-3700. 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:

   Meridian Health Plan Appeals Coordinator
   333 South Wabash Avenue, Suite 2900
   Chicago, IL 60604
   Fax: 312-980-0444

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 Provider or a family member, for example
- Choose to be represented by a legal professional
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at 800-641-3929 (Voice) or 888-460-5111 (TTY)

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.mhplan.com/il or call us at 866-606-3700 to get the form.

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service. Meridian will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Meridian may request of you and the State of Illinois an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

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

If Meridian's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Meridian's decision does not agree with the Notice of Action, 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 at no cost to you
- You have the option to be there when Meridian reviews your appeal

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Meridian will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Meridian at 866-606-3700.

What happens next?

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

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Meridian Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you.

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
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
401 S Clinton Street, 6th Floor
Chicago, IL 60607
Fax: (312) 793-2005
Or you may call 855-418-4421 (TTY: 800-526-5812)

- If you want to file a State Fair Hearing Appeal related to 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
401 S Clinton Street, 6th Floor
Chicago, IL 60607

Fax: 312-793-8573
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.

At least three (3) business days before the hearing, you will receive information from Meridian. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to Meridian and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

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

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

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

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

Meridian Health Plan Appeals Coordinator
333 South Wabash Avenue, Suite 2900
Chicago, IL 60604

Fax: 312-980-0444

What Happens Next?

We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer

You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer

The external reviewer will send you and/or your representative and Meridian a letter with their decision within five (5) 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 866-606-3700. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Meridian Health Plan Appeals Coordinator
333 South Wabash Avenue, Suite 2900
Chicago, IL 60604

Fax: 312-980-0444

What happens next?

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

We will also send the necessary information to the external reviewer so they can begin their review

As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Meridian know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Meridian with the decision within forty-eight (48) hours

MOLINA HEALTHCARE

Concerns, Complaints, Appeals and Grievances

Molina Healthcare may not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran status, ancestry, health status, or need for health services in the receipt of health services. If you think you have not been treated fairly, please call Member Services.

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

Grievances

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

Molina Healthcare 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. Molina Healthcare 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.

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

- Your provider or a Molina Healthcare 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 Molina Healthcare staff Member was rude to you.
- Your provider or a Molina Healthcare 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 (855) 766-5462, TTY 711. You can also file your grievance in writing via mail or fax at:

Molina Healthcare of Illinois
Attn: Grievance and Appeals Dept.
1520 Kensington Road Suite 212
Oak Brook, IL 60523
Fax: (855) 502-5128

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Member ID number. You can ask us to help you file your grievance by calling Member Services at (855) 766-5462, TTY 711.

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

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Molina Healthcare in writing the name of your representative and his or her contact information. An Authorized Representative Designation Form is included in this handbook. It is also available online at www.MolinaHealthcare.com or by calling Member Services at (855) 766-5462, TTY 711.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information. The Appeals and Grievance department will provide a resolution or recommendation within ninety (90) calendar days from the date you filed your grievance. You will also get a letter from Molina Healthcare with our resolution.

Appeals

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

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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

Here are two ways to file an appeal.

1. Call Member Services at (855) 766-5462, TTY 711. 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:

Molina Healthcare of Illinois
Attn: Appeals & Grievances
1520 Kensington Road Suite 212
Oak Brook, Illinois 60523
Fax: 855-502-5128

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 Provider or a family member, for example.
- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at (800) 641-3929 (Voice) or (888) 460-5111 for TTY.

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at www.MolinaHealthcare.com.

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

Molina Healthcare will send our decision in writing to you within fifteen (15) business days of the date we received your appeal request. Molina Healthcare may request an extension up to fourteen (14) more calendar days to make a decision on your case if we need to get more information before we make a

decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

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

If Molina Healthcare's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If Molina Healthcare's decision does not agree with the Notice of Action, 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 Molina Healthcare reviews your appeal.

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal.

Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Molina Healthcare 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 Molina Healthcare at (855) 766-5462 or TTY 711.

What happens next?

After you receive the Molina Healthcare appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within thirty (30) calendar days of the date on the Decision Notice. You can

choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) calendar days of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within ten (10) calendar days of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

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

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

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program (CCP)) services, send your request in writing to:

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

  Or you may call (855) 418-4421, TTY: (800) 526-5812

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

  Illinois Department of Human Services
  Bureau of Hearings
  69 W. Washington Street, 4th Floor
  Chicago, IL 60602

  Fax: (312) 793-8573
  Email: DHS.HSPAppeals@illinois.gov

  Or you may call (800) 435-0774, TTY: (877) 734-7429

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.

At least three (3) business days before the hearing, you will receive information from Molina Healthcare. 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 Molina Healthcare and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

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

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

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

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

Molina Healthcare of Illinois
1520 Kensington Road Suite 212
Oak Brook, IL 60523
Fax: (855) 502-5128

What Happens Next?

We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Molina Healthcare a letter with their decision within five (5) 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 (855) 766-5462, TTY 711. To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.

Molina Healthcare of Illinois
1520 Kensington Road Suite 212
Oak Brook, IL 60523
Fax: (855) 502-5128

What happens next?

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

- We will also send the necessary information to the external reviewer so they can begin their review.

- As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Molina HealthCare know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Molina HealthCare with the decision within forty eight (48) hours.

NEXTLEVEL HEALTH

GRIEVANCES AND APPEALS

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

Grievances

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

NextLevel Health 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. NextLevel Health 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.

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

- Your provider or a NextLevel Health 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 NextLevel Health staff member was rude to you.
- Your provider or a NextLevel Health 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. You can also file your grievance in writing and then mail or fax to:

NextLevel Health
Attn: Grievance and Appeals Dept.
3019 W. Harrison St
Chicago, IL 60612

Fax: (312) 324-0665

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

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.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform NextLevel Health in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

Appeals

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

Not approving or paying for a service or item your provider asks for

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

If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get a "Notice of Action" 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

Here are two ways to file an appeal.

1) Call Member Services at (312) 878-2778 or toll free at 1-844-807-9734. 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:

NextLevel Health
3019 W. Harrison St
Chicago, IL 60612
Fax: (312) 324-0665

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 lawyer or legal professional.
- If you have a waiver for Disabilities, Traumatic Brain Injury or HIV/AIDS, you may also contact CAP (Client Assistance Program) at 1-800-641-3929 or 1-888-460-5111 (TTY).

To appoint someone to represent you, you have the option to: 1) Send us a letter informing us that you want someone else to represent you and include his or her contact information in the letter or, 2) Fill out the Authorized Representative Appeals form. You may find this form on our website at: www.NextLevelHealthIL.com

Appeal Process

We will send you an acknowledgement letter within three (3) business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

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

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

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

If NextLevel Health's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the appeal review. If NextLevel Health's decision does not agree with the Notice of Action, 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 NextLevel Health reviews your appeal.

How can you speed up your Appeal?

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

(24) hours to inform you of our decision and will also send you and your authorized representative the Decision Notice.

How can you withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

NextLevel Health 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 NextLevel Health Member Services.

What happens next?

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

State Fair Hearing

If you choose, you may ask for a State Fair Hearing Appeal within thirty (30) 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 ten (10) calendar days of the date on the Decision Notice. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the NextLevel Health Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include his or her 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 request assistance.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver (Community Care Program - CCP) services, send your request in writing to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: (312) 793-2005

Email: HFS.FairHearings@illinois.gov

Or you may call (855) 418-4421, TTY: (800) 526-5812

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

Illinois Department of Human Services
Bureau of Hearings
69 W. Washington Street, 4th Floor
Chicago, IL 60602

Fax: (312) 793-8573

Email: DHS.HSPAppeals@illinois.gov

Or you may call (800) 435-0774, TTY: (877) 734-7429

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 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.

At least three (3) business days before the hearing, you will receive information from NextLevel Health. 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 NextLevel Health and the Impartial Hearing Officer at least three (3) business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

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

Continuance or Postponement

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

Failure to Appear at the Hearing

Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

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

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

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

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

NextLevel Health
3019 W Harrison St
Chicago, IL 60612
Fax: (312) 324-0665

• We will review your request to see if it meets the qualifications for external review. We have five (5) business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.

• You have five (5) business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and NextLevel Health a letter with their decision within five (5) calendar days of receiving all the information they need to complete their review.

Fast 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 NextLevel Member Services. 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. Your letter must ask for an external review of that action.

NextLevel Health
3019 W. Harrison St
Chicago, IL 60612
Fax: (312) 324-0665

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

• We will also send the necessary information to the external reviewer so they can begin their review.

• As quickly as your health condition requires, but no more than two (2) business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and NextLevel Health know what their decision is verbally. They will also follow up with a letter to you and/or your representative and NextLevel Health with the decision within forty-eight (48) hours.