meridian

MICHIGAN
Member Handbook

Effective date: November 15, 2024

mimeridian.com

Member Services: **1-888-437-0606** (TTY/TDD: **711**)

CAD_170346E_ State Approved 11152024

MI5CADMHB70346E_1124
HB07

Table of Contents

Welcome to Meridian

Meridian has a contract with the Michigan Department of Health and Human Services to provide healthcare services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Meridian. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Member Services. You can also access this handbook on our website at **mimeridian.com**.

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Member Services at **1-888-437-0606** (TTY/TDD: **711**) for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Meridian complies with all applicable federal and state laws with this matter.

¿Habla español? Por favor contacte a Meridian al **1-888-437-0606** (TTY/TDD: **711**).

Hearing and Vision Impairment

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling **711**.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Member Services at **1-888-437-0606** (TTY/TDD: **711**) to request materials in a different format to meet your needs.

Meridian makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency.
- Of diverse cultural and ethnic backgrounds.
- With a disability.
- Regardless of gender, sexual orientation, or gender identity.

Important Numbers and Contact Information

Member Services Toll-Free Help Line	**1-888-437-0606**
Member Services Help Line TTY/TDD	**711**
Website	**mimeridian.com**
Address	Meridian 777 Woodward Ave, Suite 700 Detroit, MI 48226
24 Hour Toll-Free Emergency Line	**1-888-437-0606**
24 Hour Toll-Free Nurse Advice Line	**1-888-437-0606** select prompt from menu
Pharmacy Services	**1-866-984-6462**
Transportation Services (non-emergency)	**1-800-821-9369** (TTY: **711**) or **1-888-437-0606** select prompt from menu
Dental Services	**1-855-898-1478** (TTY: **711**) or **1-888-437-0606** select prompt from menu
Vision Services	**1-888-437-0606**
Mental Health Services	**1-888-222-8041**
To file a complaint about a healthcare facility	Michigan Department of Licensing and Regulatory Affairs BHP Complaint & Allegation Division P.O. Box 30670 Lansing, MI 48909-8170 Phone: **1-517-284-1837** Email: **bhpinformation@michigan.gov**
To file a complaint about Medicaid services	Michigan Department of Insurance and Financial Services: **1-877-999-6442** or visit **michigan.gov/difs**

Important Numbers and Contact Information

To request a Medicaid Fair Hearing	Michigan Administrative Hearing and Rules for the MDHHS P.O. Box 30763 Lansing, MI 48909 Fax: **1-517-763-0146**
Grievance and Appeals	**1-888-437-0606**
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	Report to Meridian staff and have incident filed: **1-888-437-0606** Statewide 24-hour Abuse Line: **1-855-444-3911**
To report Medicaid fraud and/or abuse	**Mail:** Meridian Attn: Fraud, Waste and Abuse Department 777 Woodward Ave, Suite 700 Detroit, MI 48226 Toll-Free: **1-844-667-3560** Email: **Special_Investigations_Unit@CENTENE.com**
To find out information about domestic violence	National Domestic Violence Hotline: **1-800-799-SAFE (7233)** Statewide 24-hour Abuse Line: **1-855-444-3911** **michigan.gov/msp/services/safetytips/safety-information/domestic-violence-awareness**
To find information about urgent care	**1-888-437-0606 (TTY/TDD: 711)**
Disease Management and Tobacco Cessation	"Healthy Solutions for Life" **1-877-236-0253**
Michigan ENROLLS	**1-888-367-6557**
Michigan Beneficiary Help Line	**1-800-642-3195 (TTY/TDD: 1-866-501-5656)**
MIChild Program	**1-888-988-6300**

Important Numbers and Contact Information

MDHHS office locations and phone numbers	**michigan.gov/mdhhs/inside-mdhhs/county-offices**
Women, Infants and Children (WIC)	**1-800-942-1636**
Free service to find local resources. Available 24/7	**2-1-1**
Social Security Administration	**1-800-772-1213 (TTY/TDD: 1-800-325-0778)**
In an emergency	**9-1-1**
Suicide and Crisis Lifeline	**9-8-8**

Identification Cards

Your State-Issued Medicaid ID Card

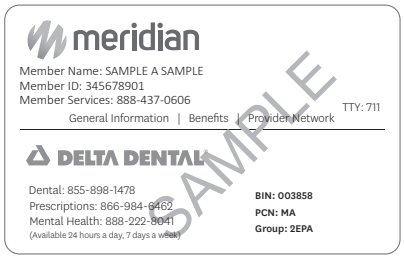
When you have Medicaid, the Michigan Department of Health and Human Services (MDHHS) will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that Meridian does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.

If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at **1-800-642-3195**. This number is located on the back of your mihealth card.

It is important to keep your contact information up to date, so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting michigan.gov/mibridges. If you do not have an account, you can create one by selecting "Register." Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

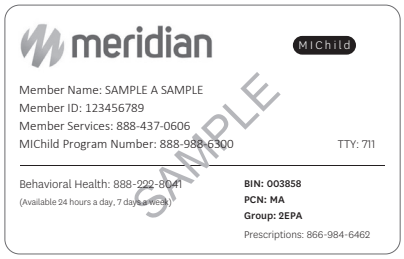
Your Meridian Member ID Card

You should have received your Meridian ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.



Meridian

Healthy Michigan Plan



MIChild program

Your Meridian member ID card lists this information:

- Your name.
- Medicaid ID number.
- Member Services phone number.
- Other special instructions and information.

If you have questions about this coverage or need a new Meridian Member ID card, you should call Member Services at **1-888-437-0606** (TTY/TDD: **711**).

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards.
- Call your local MDHHS office to change your records if your name or address changes.
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card.
- Do not let anyone else use your cards.

Getting Help from Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at **1-888-437-0606** (TTY/TDD: **711**), 24 hours a day, seven days a week.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call **1-888-437-0606** (TTY/TDD: **711**), select member, and select nurse advice line from the menu prompt, if this is an emergency, please call **911**.

Our Website

You can visit our website at **mimeridian.com** to access online services such as:

- Special healthcare program information.
- Member newsletters.
- Privacy information.
- Online Provider Directory.
- Drug Formulary.
- Useful links.
- Health tips.

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. Meridian recognizes the trust needed between you, your family, and your providers. Meridian staff have been trained in keeping strict member confidentiality.

Moving?

Don't forget to call us and Michigan Enrolls with your new address.

- Michigan ENROLLS: **1-800-975-7630**
- Meridian: **1-888-437-0606** (TTY/TDD: **711**)

Manage Your Digital Health Records/Member Mobile Application

You now have full access to your health records on your mobile device, which lets you manage your health better and know what resources are open to you.

- A new provider can pull up your health history from the past five years.
- You can use an up-to-date Provider Directory to find a provider or specialist.
- A provider or specialist can use your health history to diagnose you and make sure you get the best care.
- You can see if a claim is paid, denied or still being processed.
- You can take your health history with you as you switch health plans.*

**In 2022, members can start to request that their health records go with them as they switch health plans.*

It's easy to find information** on:

- Claims (paid and denied).
- Specific parts of your clinical information.
- Pharmacy drug coverage.
- Healthcare providers.

***You can get information for dates of service on or after January 1, 2016.*

Visit your online member account through the member portal at **mimeridian.com**

If You Get a Bill or Statement

Call **1-888-437-0606** (TTY/TDD: **711**) if you have any problems with medical bills for covered care. Sometimes you may get a bill for care you had before you joined our plan. Call your provider's office for help with this type of bill. If you get a bill by mistake, send it to:

Meridian
777 Woodward Ave, Suite 700
Detroit, MI 48226

Transition of Care

If you're new to Meridian, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are a Meridian member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition.
- The doctor has a restriction and you might be at risk.
- The doctor is not willing to continue your care.
- Care with the non-participating doctor was started after you enrolled with Meridian.
- The doctor does not meet Meridian policies or criteria.

Meridian will help you choose new doctors and help you get services in our network. Your doctor may call Member Services if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at **1-888-437-0606** (TTY/TDD: **711**) to request transition of care services or if you have any questions about your care.

Getting Care

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the healthcare provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member, or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor.
- Family practice doctor.
- Nurse Practitioner.
- Internal medicine doctor.
- Pediatrician doctor.
- OB/GYN doctor.

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at **findaprovider.mimeridian.com/location**. You can view or print the Provider Directory from the website. You can also request a copy of our Provider Directory, free of charge by calling **1-888-437-0606** (TTY/TDD: **711**). Member Services can also give you up-to-date information about the provider. This includes name, address, telephone numbers, whether they are accepting new patients, professional qualifications, languages spoken, gender, medical school attended, residency completion, specialty, and board certification status. Remember provider information changes often. Visit our website for the most up-to-date information. Call Member Services if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

If you have certain healthcare needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Member Services for more information.

Make sure you ask the provider office if they participate in the Meridian network.

Getting Care from Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at **1-888-437-0606** (TTY/TDD: **711**).

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care from a Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special healthcare needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. You do not need referral to see a specialist within the State of Michigan. Talk to your doctor or call Member Services for more information.

Out-of-Network Services

You must get most of your care from providers in our provider network. Member Services can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network.

This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

You can ask for non-urgent care if you are out of the county, or out of the state, in some situations. You must get prior authorization to do so.

Away From Home

Take these steps if you are away from home and need medical care:

- If it is not an emergency, call your provider to talk about your illness or health concerns.
- If you feel that you are having a health emergency, go to the nearest emergency room or call **911**.

If you are traveling **out of state**, please be aware that only emergency benefits are covered.

Out of State Services

All services out of the state require prior authorization unless they are in network.

Out of Country Services

Healthcare services provided outside the country are not covered by Meridian.

Physician Incentive Disclosure

For information on how we pay providers in our network, please call member services at **1-888-437-0606** (TTY/TDD: **711**).

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve service, we will notify the doctor and send you a written notice of the decision.

Our providers and healthcare staff make decisions based on the care that is right for you and what is covered by your Medicaid benefits. This is called Utilization Management (UM). UM is based on national standards of care created by providers.

We do not reward providers for denying you care. Our employees who make UM decisions are not rewarded for limiting your care.

You can call Member Services at **1-888-437-0606** (TTY/TDD: **711**) if you have a question about your benefits, providers, or any service you have asked for or received. We are open Monday-Friday, 8 a.m. to 6:30 p.m., Eastern time. When our representatives answer the phone, they will greet you by telling you their name, title, and company. All calls you make are toll-free.

We offer free TTY/TDD services to our members with hearing problems. The TTY/TDD line is open 24 hours a day, seven days a week, by dialing **711**. Interpreter services and translated materials are also available and free for our members.

Call Member Services at **1-888-437-0606** (TTY/TDD: **711**) for help getting an interpreter or to ask for our materials in another language.

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a Meridian network provider. Second opinions do not require prior authorization from us. Please call Member Services to learn how to get a second opinion.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a Meridian member, you do not have to pay copays for covered services under the Medicaid or Healthy Michigan Plan. See the Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. If you want a printed copy of the COC or have questions regarding your benefits, contact Member Services.

Make sure a service is covered before the service is done. You may have to pay for services not covered by Meridian under the Medicaid program.

Meridian does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses and mental health needs without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, other illnesses, and mild to moderate mental healthcare, you can connect with a provider through your phone or computer. Telehealth lets you receive care where you are, when you need it. Providers can diagnose, treat, and even prescribe medicine, if needed. Call your provider's office to see if they offer telehealth services or contact Member Services for more information.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from correct providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency.
- Seeing too many different providers instead of your PCP.
- Getting more medicines than may be safe.
- Activity that may indicate fraud.

Using the right health services in the right amount helps us make sure you're getting the very best care.

Covered services include:

It is important you understand the benefits covered under your plan. As a Meridian Medicaid member, you do not have to pay copays for covered services.

Behavioral Health	
Outpatient Behavioral Health (BH)	Covered BH offers emotional support, guidance, and counseling options. Our BH staff can help you get the care you need. Call **1-888-222-8041** for help. We do not cover inpatient mental health and substance use disorder care. This care is covered by the State. See the BH Care section in "Care Covered by the MDHHS" for more information.
Children's Care	
Circumcisions	Covered – May require PA No PA required if performed prior to leaving the hospital following birth.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (under age 21)	Covered **Care includes:** • Developmental screening. • Vision testing. • Hearing testing. • Follow-up services.
Immunizations & Vaccines (shots)	Covered – Certain immunizations and vaccines may require PA. You can get these at your provider's office or the local health department. They are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule.
Lead Screening	Covered • Lead screenings can be done at your provider's office or local health department. The first blood lead test should be given before age one. A second test is due before age two.

Children's Care (continued)	
Newborn Care (newborn screening)	Covered
Office Visits	Covered **Care includes:** • Well-child visits. • Routine and sick visits. • Routine and preventive care.
Durable Medical Equipment (DME)	
Asthma Supplies	Covered – May require PA. • Peak flow meter. • Spacers. • Nebulizers/masks.
Durable Medical Equipment (Wheelchairs, walkers, hospital beds, etc.)	Covered – May require PA.
Hearing Aids	Covered – PA required. • Limit one per five years. • Up to 36 disposable hearing aid batteries per hearing aid every six months. • Ear molds.
Medical Supplies	Covered – May require PA.
Prosthetics/Orthotics	Covered – May require PA.

Emergency and Urgent/Hospital Care	
Emergency Room Care, Ambulance & Other Emergency Transportation	Covered Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. **Here are some examples of emergencies:** • Convulsions. • Uncontrollable bleeding. • Chest pain. • High fever. • Serious breathing problems. • Knife or gunshot wounds. • Broken bones. • Loss of consciousness (fainting or blackout). • You can get this care out-of-network, including post-stabilization care. Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition. Air ambulance and ambulance services for emergency transportation are covered. Hospital-billed ambulance services to and from a nursing facility or your home is also covered. • You may contact **911** or your provider to obtain emergency transportation.
Inpatient Rehabilitation	Covered – PA required.

Emergency and Urgent/Hospital Care (continued)	
Long Term Acute Care Hospital	Covered – PA required.
Medical Inpatient Care	Covered – PA required.
Skilled Nursing Facility	Covered – PA required. There is a 45-day limit for this care in a rolling calendar year.
Urgent Care Visits	Covered **Urgent care is for problems that need prompt medical attention but are not life threatening. Here are some examples of urgent care:** • Sore throat or cough. • Back pain. • Tension headache. • Earache. • Flu or cold symptoms. • Frequent urination. • Minor sickness. • Minor injury. Call Member Services at **1-888-437-0606** (TTY/TDD: **711**) to find an urgent care center closest to you.

General Health Care	
Annual Physical Exam	Covered
Family Planning	Covered Family planning care is covered with no out-of-pocket costs. Both men and women can get this care. Family planning helps you plan when you want to add to your family.
Follow-Up Visits	Covered
Flu Shots	Covered
Health Education	Covered
Immunizations	Covered – Certain immunizations may require PA.
Office Visits	Covered
Specialist Visits	Covered
Hospice	
Hospice Care	Covered – PA required. Hospice care is for people with an illness causing limited life expectancy as determined by your provider. It is most often given in the home. Your provider will help you arrange the care you need.

Other Covered Care and Programs	
Acute Mental Health and Specialty Behavioral Health Services	Covered and managed by local Pre-Inpatient Health Plans and associated Community Health Agencies. **Covered services include:** 1. Acute psychiatric inpatient. 2. Partial hospitalization programs. 3. Community-based mental health services. 4. Intensive outpatient services.
Care Coordination	Covered The Care Coordination program links you to services and resources that will help with management of your chronic conditions.
Chiropractic Care	Covered – PA required after the first 18 visits.
Diabetes Care	Covered – May require PA. **This includes:** • Glucometers and lancets. • Dilated retinal eye exams. • Insulin injection aids. • Pumps. • Some syringes and needles. • Therapeutic molded shoes. • Diabetic education classes. • Diabetic footwear. • Continuous glucose monitors are covered in certain instances. Meridian offers One Touch Verio diabetic supplies such as a glucometer, test strips, and lancets at any participating network pharmacy. Only drug medications that are on the formulary are covered.

Other Covered Care and Programs (continued)	
Dialysis	Covered – Notification requested. • End Stage Renal Disease (ESRD) and other conditions that may require dialysis.
Federally Qualified Health Center (FQHC)	Covered An FQHC offers primary and preventive healthcare. An FQHC may also give dental, mental health, or substance abuse care. You can go to any FQHC in any county. You do not need a referral from your provider.
Miscellaneous, unlisted or no other specified procedures	PA required.
Pain Management Injections	Covered – May require PA.
Prescription and Over-the-Counter (OTC) Drugs	Covered – may require PA. Please see our formulary at **mimeridian.com** for details. Please call the Pharmacy department for a printed copy or if you have questions.
Rural Health Clinic (RHC)	Covered An RHC offers primary and preventive healthcare services in rural communities. You can go to any RHC in any county. You do not need a referral to go to an RHC.
Smoking Cessation (quitting smoking)	Covered **Nicotine Replacement Therapy (NRT) such as:** • Gum • Lozenges • The patch Call Member Services to enroll in Meridian's Lifestyle Management Program for information on our Smoking Cessation Program at **1-888-437-0606**.

Other Covered Care and Programs (continued)	
Tribal Health Center (THC)	Covered
Vision Benefit	**Eye Care and Eyeglasses** Covered – May require PA. **Those 20 years old and younger receive each year:** • One eye exam. • One pair of glasses. **Those 21 years old and over receive every two years:** • One eye exam. • One pair of glasses. Replacement of frames/lenses due to loss or breakage (if they cannot be repaired) is covered once each year for members ages 21 and over and twice each year for members under age 21. "One year" is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered. More visits and eyeglasses are covered if medically necessary. Other medically necessary treatment for eye illness or injury is covered. Call your provider right away if you injure your eye or have other eye problems. Contact lenses need prior authorization and are covered only if medically necessary.
Weight Management (WM)	**Covered.** • Bariatric Surgery: For ages 18 and up. PA Required. • Weight Management Program Call Member Services to enroll in Meridian's Lifestyle Management Program for information on our Weight Management Program at **1-888-437-0606**.
Outpatient Care	
Audiology Testing (hearing test)	Covered
Cardiac and Pulmonary Rehab	Covered – May require PA. PA required for more than 36 visits.

Outpatient Care (continued)	
Diagnostic Testing, Urinalysis and Urine Cultures	**Covered – PA may be required.** • Blood tests. • Anemia testing. • Pregnancy testing. • Radiology services (x-rays).
Home Health Care	Covered – PA required. Custodial care (care provided by non-skilled or non-licensed person) is not covered.
Radiology Services (x-rays)	Covered – May require PA.
Rehabilitative/Habilitative Services and Devices	Covered – May require PA. **This type of care is given after serious illness or injury to restore function:** • Physical therapy. • Occupational therapy. • Speech/language therapy. • Reconstructive surgery. • Chiropractic care (see section below). • Prosthetics. • Orthotics. • Medical equipment. • Medical supplies.
Specialty Care (Office Visits and Clinics)	Covered – PA may be required. You do not need prior authorization to see a specialist within the State of Michigan. Talk to your provider to see if you need specialty care. Your provider will refer you to a specialist if needed.

Reproductive Care	
Abortions	PA required. Covered if medically necessary as defined by Michigan law.
Birth Control	**Covered if on the drug formulary and prescribed by a provider. Certain contraceptives may require PA. Some covered birth control includes:** • Oral contraceptives. • Depo-Provera shots. • Select IUDs when medically appropriate. • Diaphragms. • Some over-the-counter family planning supplies (foam, condoms, spermicidal jelly, or cream). • Emergency contraceptive pills, as needed. • Long acting reversible contraceptives (LARC) after giving birth.
Family Planning	Covered **Family planning helps you plan when you want to add to your family. Family planning care is covered with no out-of-pocket costs. Both men and women can get this care. Care includes:** • Provider visits. • Pregnancy testing. • Birth control counseling. • Birth control methods (condoms, pills, IUDs). • Testing for sexually transmitted infections. • Voluntary sterilization. • HIV/AIDS testing and care. • Rides to pregnancy-related appointments and for a mother to visit their hospitalized infant.

Reproductive Care (continued)	
Mammogram/Breast Cancer Screening (40 years and older)	Covered
Maternal Infant Health Program (MIHP)	Covered The Maternal Infant Health Program (MIHP) is a program for Medicaid-eligible pregnant people and infants to promote healthy outcomes. Meridian works with certified MIHP programs to administer this benefit. **Your covered care includes:** • Preventive counseling. • Assessments/Evaluations. • Birthing classes. • Parenting class. • Transportation to appointments.
Obstetric Care	Covered **Each pregnant member is covered for:** • Doula Services (6 visits). • Group prenatal classes (12 classes). • Provider and hospital care before your baby is born (prenatal care). • Delivery. • Care after birth (postpartum care). • Certified midwife care. • Birthing and parenting classes. You may choose an obstetrician (OB) or OB/GYN for prenatal and postpartum care without a referral. Doulas must be certified and registered with MDHHS. You can stay in the hospital up to two days after a normal vaginal delivery and up to four days after a cesarean delivery. Certain services may require PA.
Pap Test	Covered One covered every 12 months.
Pregnancy Testing	Covered

Reproductive Care (continued)	
Reproductive Health Screenings	Covered **Covered care includes:** • One routine gynecological exam every 12 months. • Treatment of breast cancer is also covered, including: – Reconstructive plastic surgery. – Chemotherapy and/or radiation therapy. – Physical therapy. – Psychological and social support services. – Other services when medically necessary and ordered by your provider.
Sterilization	Covered
Surgical Breast Biopsy	Covered
Surgery	
Non-emergent, Inpatient, Ambulatory, Outpatient, Emergency and Reconstructive Surgeries	Covered – May require PA.
Transplants	Covered – PA required. **It must be medically necessary and non-experimental. These organ transplants are covered:** • Cornea. • Heart. • Lung. • Kidney. • Bone marrow. • Liver. • Pancreas. • Small bowel.

Value-Added Benefits	
Disease Management Programs	Programs focus on empowering members, goal setting, and creating healthy behaviors to manage and prevent disease. Programs are available for Asthma, COPD, Coronary Artery Disease (CAD) and Diabetes. For more information, see page 46.
My Health Pays®	You can earn My Health Pays rewards from Meridian when you complete healthy activities! For more information, see page 45.
Start Smart for Your Baby	Start Smart for Your Baby is our special program for people who are pregnant. Please call Member Services as soon as you find out you're pregnant. For more information, see page 41.

Care Covered by the Michigan Department of Health and Human Services (MDHHS)

This is a list of care covered by the MDHHS. You must use your mihealth card to get this care. This is not a full list

MDHHS Covered Care and Programs	
Custodial Care	Custodial care refers to care provided by a non-skilled or non-licensed person.
Psychotropic and HIV/AIDS Drugs	MDHHS covers these. Call the Michigan Beneficiary Helpline for information at **1-800-642-3195**.
Skilled Nursing Facility	MDHHS covers intermittent or short-term restorative or rehabilitative care **after** the Meridian 45-day benefit is used.
Therapies (Speech, Language, Occupational and Physical)	Services, including therapies (speech, language, physical, occupational), provided to persons with intellectual and/or developmental disabilities (I/DD) that are billed through Community Mental Health Services Program Providers or Intermediate School Districts.
Traumatic Brain Injury (TBI) Program	MDHHS offers rehabilitative and home and community-based care to persons who suffered a qualifying traumatic brain injury (TBI). Call the Michigan Beneficiary Helpline at **1-800-642-3195** for more information.

Care Coordination

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through healthcare. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications.
- Making a plan of care to help you identify and meet your health goals.
- Linking you with services and community resources near you, including the local health departments.
- Helping you better control your healthcare needs.
- Collaborating with your providers.
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits.

Call Member Services for more information about the care coordination program.

Special Healthcare Programs

Program Name	Description
Care Coordination	Helps members with all their healthcare needs by giving them tools to help manage their chronic conditions.
Choose Tomorrow	Suicide prevention program that uses early detection and intervention strategies to help those at risk for suicide.
Flu Outreach	Encourages members to get the flu shot in order to help with preventive care and keep members healthy.
Health Assistance, Linkage and Outreach (HALO) Program	Supports members experiencing substance use disorder (SUD) or those at risk by providing assistance in finding treatment and recovery resources.
Sickle Cell Disease Program	Provides additional support to members and their families with treatment needs and barriers to care.
Smoking Cessation	Offers educational materials, a personal Smoking Cessation Health Coach, and coaching calls to help members quit smoking.
Transition of Care	Helps with the transition from hospital to home by providing support and education for the member, family, and caregiver.
We Treat Hepatitis C	Provides support and education regarding recommended testing and treatment guidelines.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your healthcare.

A care coordinator helps you:

- Coordinate care between healthcare providers.
- Set personal goals to manage your medical conditions.
- Talk to your doctors or other providers when you need help.
- Understand your medical conditions.
- Access community-based supports, services, and resources.

If you are interested in joining this program, please call Member Services to be connected with a care coordinator.

We cover most care without a referral or medical review. However, some care needs Prior Authorization (PA). Your provider has a list of care that needs PA. Your provider needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. The PA request must be approved before you can get the care. When a provider submits a PA form, clinical staff reviews the request(s) and decides if:

- It is medically necessary, which means that the healthcare services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms meet accepted standards of medicine.
- You can get the care from a provider in our network.
- Seeking services out of network may require PA. All out-of-state services require prior authorization.

Providers may refer a member for care coordination via the secure Meridian Provider Portal, utilizing the "Notify CM" button, or by calling Meridian at **1-888-437-0606** (TTY/TDD: **711**).

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

- 3-5 days
- 2 weeks
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight, and BMI checked. Providers can talk about health, safety, and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid. For more information on EPSDT, go to the Bright Futures website at **brightfutures.aap.org/**.

EPSDT checkups include:

- ✓ Well-care visits.
- ✓ Health history and physical exam, including school and sports physicals.
- ✓ Developmental screening.
- ✓ Health education guidance.
- ✓ Hearing, vision, and dental screening assessment.
- ✓ Physical and mental developmental/behavioral assessments.
- ✓ Crucial lab tests, including lead screening.
- ✓ Nutrition assessment.
- ✓ Immunizations.
- ✓ Follow-up services.

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Meridian.

There is no cost for this program. It doesn't change your child's Meridian benefits, service, or doctors. CSHCS provides services and resources through the following agencies:

1. **Assistance from the local health department (LHD) with:**
   - Community resources – schools, community mental health, respite care, financial support, childcare, Early On®, and WIC.
   - Healthcare transition to adulthood.

2. **Assistance from the Family Center for Children and Youth with Special Health Care Needs:**
   - CSHCS Family Phone Line, **1-800-359-3722** (toll-free), open Monday–Friday, 8 a.m. to 5 p.m.
   - Parent-to-parent support network.
   - Parent/professional training programs.
   - Financial help to go to conferences about CSHCS medical conditions.
   - Help for siblings of children with special needs to attend the "Relatively Speaking" conference.

3. **Assistance from the Children's Special Needs (CSN) Fund. The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. Call 1-517-241-7420 to see if you qualify for help from the CSN fund. Examples of items CSN may be able to provide are:**
   - Wheelchair ramps.
   - Van lifts and tie downs.
   - Therapeutic tricycles.
   - Air conditioners.
   - Adaptive recreational equipment.
   - Electrical service upgrades for eligible equipment.

If you meet the specific CSHCS criteria, you will get a letter telling you that you were placed in CSHCS, explaining the program, and giving who you can contact if you have questions.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at **1-800-359-3722** from 8 a.m. to 5 p.m., Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines, and more. For help finding your local county health department, visit your county's website or **Michigan.gov**. Call Member Services for assistance.

Children's Special Needs Fund:

The Children's Special Needs Fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts, and mobility equipment. To see if you qualify for help from this fund, call **1-517-241-7420**.

CSHCS member transitioning to adulthood:

We can help members who have special healthcare needs on how to plan a successful move from pediatric healthcare to adult healthcare services.

Community Health Workers (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating healthcare. CHW serve as a bridge between healthcare and social services by building trusting relationships. CHW's full range of services include:

- Meeting face to face to improve your access to healthcare.
- Helping others find providers and set up visits.
- Finding local support, like food and housing.
- Teaching ways to live a healthy life.
- Helping with provider follow-up visits after going to the hospital or emergency room.
- Helping set up rides for medical or pharmacy visits.

Contact Member Services for more information.

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries enrolled in Healthy Michigan Plan, as well as enrollees ages 21 and older enrolled in Medicaid. We are contracted with Delta Dental to provide your dental benefits. Children under age 21 and enrolled in Medicaid are automatically enrolled into the Healthy Kids Dental program.

If you have any questions about your dental services, please contact Delta Dental at **1-855-898-1478** (TTY: **711**) and select prompt from menu.

Covered dental services include:

Adjunctive General Services	
General anesthesia	Covered
Diagnostic	
Oral Exam (up to two times in a calendar year)	Covered
X-rays (one in a calendar year)	Covered
Endodontic	
Root canal	Covered
Oral and Maxillofacial Services	
Alveoloplasty	Covered
Extractions	Covered
Surgical extractions	Covered
Periodontal	
Complete and partial dentures One in five years.	Covered
Comprehensive periodontal evaluation	Covered
Full mouth debridement	Covered
Periodontal maintenance	Covered
Scaling and root planning One in two years per quadrant, maximum of two quadrants per day.	Covered – PA required.
Scaling in the presence of inflammation	Covered

Preventative	
Dental sealant	Covered with specific conditions met
Fluoride Varnish	Covered for ages 19-20
Prophylaxis – Cleaning (Once every six months)	Covered
Topical application of fluoride Cannot be combined with fluoride varnish within the same six months.	Covered for ages 19-20
Removable Prosthetics	
Complete denture (upper and lower)	Covered
Denture adjustments	Covered
Denture relines	Covered
Denture repair and relines Once every two years.	Covered
Partial denture (upper and lower)	Covered
Restorative	
Amalgams	Covered
Crowns Once per five years for each tooth.	Covered
Protective restoration	Covered
Resins	Covered
Root canal	Covered

Be sure to ask your dentist if a service is covered before the service is done.
Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental** program. The two plans available are Blue Cross Blue Shield of Michigan and Delta

Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **1-800-642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: **1-800-936-0935**

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (**deltadentalmi.com**)
Phone: **1-866-696-7441**

Durable Medical Equipment

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices.
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters, and alcohol pads.
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters, and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Member Services.

Emergency Care

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions.	Broken bones.
Uncontrollable bleeding.	Loss of consciousness (fainting or blackout).
Chest pain.	Jaw fracture or dislocation.

High fever.	Tooth abscess with severe swelling.
Serious breathing problems.	Knife or gunshot wounds.

If you believe you have an emergency, call **911** or go to the emergency room. You do not need an approval from Meridian or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Foster Care Management

All foster care members will automatically be placed in care management upon enrollment with Meridian for the duration of their foster care placement. They will receive services and supports with their healthcare needs from dedicated staff. Meridian also offers care management services to members who have transitioned out of foster care, up until the age of 26.

- Upon enrollment in care management, Meridian will coordinate with State Health Liaison Officers (HLOs) to ensure all newly identified foster care enrollees under the age of 21 get a physical and mental health screening within 30 days of system entry.

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. To get more information, call Member Services.

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams.
- Medically necessary hearing aid evaluations and fittings.
- Medically necessary hearing aids.

If you need a hearing exam or think you need hearing aids, call Member Services at **1-888-437-0606** (TTY/TDD: **711**). You can also call a provider from our list of hearing providers.

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of

advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis, and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Home Health Care, Skilled Nursing Services, and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan).
- Home healthcare services for members who are homebound.
- Supplies and equipment related to home healthcare.
- Hospice care.

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker, or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Member Services.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school.
- Being absent often.
- Performing poorly at work or school.
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use.
- Needing more of the substance to feel the same effects.
- Failing when trying to cut down.
- Failing when trying to control the use of the substance.
- Spending a lot of time getting the substance.
- Spending a lot of time using the substance.
- Spending a lot of time recovering from the substance's effects.
- Giving up or reducing important social, work, or recreational activities because of substance use.
- Continuing to use the substance even though it has negative effects.

If you have questions about your mental health or substance abuse benefits call Meridian Behavioral Health Services at **1-888-222-8041**. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network. There are also family planning services and supplies available from any out-of-network provider without a referral that are covered. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

- ✓ Family planning.
- ✓ Pregnancy testing.
- ✓ Birth control and birth control counseling.
- ✓ HIV/AIDS testing and treatment of sexually transmitted diseases.
- ✓ Pregnancy care, including the Maternal Infant Health Program.

- ✓ Doula services.
- ✓ Depression screening.
- ✓ Prenatal and postpartum care.
- ✓ Midwife services in a healthcare setting.
- ✓ Delivery care.
- ✓ Parenting and birthing classes.
- ✓ Group prenatal classes.
- ✓ Mammograms and breast cancer services, such as treatment and reconstruction.
- ✓ Pap tests.

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Member Services as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children.
- Help to decide how many children to have.
- Birth control services and supplies. (It is recommended to get a pap test and chlamydia test before getting birth control).
- Sexually transmitted disease testing and treatment.
- Testicular and prostate cancer screening.
- Provider visits.
- Pregnancy testing.
- Voluntary sterilization.
- HIV/AIDS testing and care.
- Rides to pregnancy-related appointments and for a mother to visit their hospitalized infant.

Pregnancy Services

Start Smart for Your Baby is our special program for people who are pregnant. There is no cost to the member. Meridian wants to help you take care of yourself through your whole pregnancy. Our Start Smart for Your Baby staff can provide information by telephone, answer your questions, and give you support if you are having a problem. We can even arrange for a home visit, if needed.

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Member Services and your local MDHHS office as soon as you find out you are pregnant, so we can provide support.

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup seven to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Member Services to report the change. This starts the process of signing your baby up for healthcare services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Member Services if you need help.

Change in Family Size

When you experience a change in family size, contact Member Services to let us know, and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption, and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for pregnant people and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching.
- Childbirth education classes.
- Nutritional support, education, and counseling.
- Breastfeeding or formula feeding support.

- Help with personal problems that may complicate your pregnancy.
- Newborn baby assessments.
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking.
- Help with substance abuse.
- Personal care or home help services.

Meridian provides transportation to members utilizing MIHP services, including oral health services, WIC services, mental or substance use disorder treatment services, and childbirth/parenting education classes. Call Member Services for more information on how you can access these services.

Pharmacy Services

Meridian follows the Michigan Medicaid Managed Care Common Formulary. The Michigan Department of Health and Human Services (MDHHS) has created this list of drugs that all Medicaid health plans must cover. The coverage limits such a quantity, prior authorizations, and which medications are preferred are defined by this list. Some drugs are not covered by the health plan but are covered by the state Medicaid fee-for-service program instead. The table below gives more information to understand the pharmacy benefit.

Dispensing Limits, Quantity Limits, and Age Limits	Most covered drugs may be dispensed up to a maximum 30-day supply for each new or refill non-controlled substance. Certain maintenance drugs may be dispensed up to a maximum of 90-day supply. A total of 75 percent of the days supplied must have elapsed before the prescription can be refilled. For controlled substances, a total of 90 percent of the days supplied must have elapsed before the prescription can be refilled. Dispensing outside the quantity limit (QL) or age limits (AL) requires Prior Authorization (PA).
Generics and Step Therapy	**Generic Substitution:** • Meridian is a mandatory generic plan. Michigan Department of Health and Human Services (MDHHS) has mandated that some brand medications are to be covered over the generic medication. Generic medication will be dispensed when available. **Step Therapy:** • Drugs with an "ST" need Step Therapy for coverage. In some cases, you may need to try a certain drug first before Meridian covers another drug for your medical condition. This is called Step Therapy.

List of pharmaceuticals, restrictions, and preferences	The Meridian Formulary, or Preferred Drug List (PDL), is a guide to available brand name and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. The PDL is available on the Meridian website at **mimeridian.com/members/medicaid/benefits-services/pharmacy.html**. The PDL includes all drugs available without Prior Authorization (PA) and those agents that have the restrictions of Step Therapy (ST). The PA list includes those drugs that require PA for coverage. The PDL applies to drugs you receive at retail pharmacies. The PDL is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated. Annual updates and major changes in drug coverage and pharmaceutical management edits are communicated to providers and members by direct mail (e.g. fax, email, mail), as needed.
Medical Necessity Requests	If the member requires a medication that does not appear on the PDL, the member's practitioner can make a Medical Necessity (MN) request for the medication. It is anticipated that such exceptions will be rare and that PDL medications will be appropriate to treat the vast majority of medical conditions.
Pharmaceutical Management Procedures	Meridian covers needed drugs for Medicaid members. You may call a Member Service Representative for a list of drugs Meridian covers, or you can visit our website at **mimeridian.com/members/medicaid/benefits-services/pharmacy.html** for more information about your pharmacy benefit.
Subscriber Information: Provider Directory Information	Meridian's local provider network is the group of doctors, hospitals, and other healthcare providers who have agreed to provide you with your healthcare services. To search the Provider Directory, visit **mimeridian.com/members/medicaid.html** and use the "Find a Provider" tool. This tool will have the most up-to-date information about the provider network, including information such as name, address, telephone numbers, whether they are accepting new patients, professional qualifications, languages spoken, gender, specialty, and board certification status. For more information about a provider's medical school and residency, call Member Services.

Preventive Healthcare for Adults

Preventive healthcare for adults is important to Meridian. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression screening
- Prostate and colorectal screenings
- Review of current medications

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed on the next page.

Things you should do:	**Things you should not do:**
• Don't smoke or use tobacco. • Don't use drugs or drink alcohol. • Eat healthy. • Exercise. • Get enough sleep. • Go to the dentist for regular cleanings and preventive services. • Manage your stress. • Visit your doctor each year for yearly preventive care.	• Avoid going to the doctor. • Eat foods high in fat, sugar, and salt. • Forget to set up a yearly visit to your doctor. • Forget to set up your dentist visits for regular cleanings and preventive services. • Hold in your feelings or emotions if you're feeling stressed or depressed. • Live an inactive lifestyle. • Use drugs, alcohol, or tobacco.

My Health Pays® Rewards

You can earn My Health Pays® rewards from Meridian when you complete healthy activities!

$25	Well-Child Visits Ages 0-15 months. One reward requires 6 visits.
$40	Adolescent Immunizations **Ages 6-12 years. Requires all of the following:** • One dose of meningococcal vaccine. • One Tdap vaccine. • The complete HPV vaccine series.
$40	Child Immunizations **Ages 0-24 months. One time reward. Requires the following:** • Four DTap • Three IPV • One MMR • Three HiB • Three Hep B • One VZV • Four PCV • One HepA • Two or Three RV
$15	Child Lead Screening Ages 0-24 months. One time reward.
$15	Chlamydia Screening Ages 16-24. Once per year.
$25	Breast Cancer Screening Ages 50-74. Once per year.
$40	First Prenatal Visit To be eligible for this reward, you must notify us you are pregnant prior to having your baby by submitting a completed Notification of Pregnancy (NOP) form.

$35	Postpartum Visit One per pregnancy. Must be completed seven to 84 days after delivery.
$15	Dental Visit Ages 19-64. Once per year. Healthy Michigan only.

You will receive your My Health Pays® Visa® Prepaid Card when you earn your first reward from **Meridian**. Each time you complete a qualifying healthy activity, we are notified, and your reward dollars will be added to your existing card. It's that simple! Rewards program subject to change at discretion of the health plan. Please see Meridian's website for most up-to-date information.

Disease Management

- Members can enroll by calling member services.
- Programs focus on empowering members, goal setting, and creating healthy behaviors to manage and prevent disease.

Program	Topic	Overview
Cardiac Program	• Coronary Artery Disease (CAD) • Heart Failure	The cardiac program provides telephonic outreach, education, and support services to promote participant adherence to cardiac guidelines, prevent subsequent cardiac events, and optimize functional status.
Diabetes Program	• Diabetes	The Diabetes program provides telephonic outreach, education, and support services to optimize blood glucose, blood pressure, and lipid control to minimize the development and/or progression of diabetic complications; optimize nutrition, healthy-eating options, and self-care behaviors; improve self-management skills to increase compliance associated with HbA1c, lipids, and blood pressure testing; and promote statin therapy for patients with cardiovascular disease and diabetes.
Respiratory Program	• Asthma • COPD	The respiratory program, focused on Asthma and COPD, provides telephonic outreach, education, and support services to promote adherence to treatment guidelines, prevent acute exacerbations, reduce healthcare utilizations, promote therapeutic regimen, participant self-management, and annual physician visits, and optimize functional status.

Routine Care

Routine care is for things like:

- Yearly wellness exams.
- School physicals.
- Health screenings.
- Immunizations.
- Vision and hearing exams.
- Lab tests.

Your doctor should set up a visit within 30 business days of request.

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. Meridian can also help you. To get more information, call Member Services. We cover the following services to help you:

- Therapy and counseling services.
- Educational materials.
- Prescription inhalers or nasal sprays used to stop smoking.
- Non-nicotine drugs.
- Over-the-counter items to help you stop smoking:
  - Patches
  - Gums
  - Lozenges
- Meridian's Tobacco Cessation:
  - Program offers telephonic outreach, education, and support services to members in support of changing unhealthy behaviors and motivating individuals to achieve their health goals.
  - This program is offered to current tobacco users with an interest in quitting in the next 30 days.
  - Members can reach out to Member Services to be enrolled.
  - Programs for:
    - Adults
    - Minors
    - Pregnant members

- Program overview:
    - Quit date preparation.
    - Identification of tobacco cues and coping strategies.
    - Individualized cessation plan.
    - Risk factor education.
    - Instruction on appropriate use of prescription and over-the-counter pharmacotherapy, including nicotine replacement therapy.

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation through SafeRide Health. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. Rides to ongoing services are also provided, such as dialysis, chemotherapy, substance abuse disorder (SUD) services, physical, speech and occupational therapy. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

To schedule a ride or ask for gas reimbursement for all your non-emergency medical appointments, call Meridian transportation at **1-800-821-9369** (TTY: **711**). Hours of operation are 24 hours a day, 7 days a week, 365 days a year, including on holidays. Please call at least 72 hours before your trip. Rides can be scheduled up to 6 weeks in advance. Members and individual drivers must register with SafeRide, which can be done by visiting **saferidehealth.com/meridian**. Members and individual drivers need to sign up at least five business days prior to requesting a ride.. You can request same-day transportation for an urgent non-emergency appointment. Visit **saferidehealth.com/meridian** for additional information related to your NEMT benefit.

Have this information ready when you call:

- Your name, Medicaid ID number, and date of birth.
- The address and phone number of where you will be picked up.
- The address and phone number of where you are going.
- Your appointment date and time.
- The name of your provider.

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor. If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will still get through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.

Please be sure to call us as soon as possible if you need to cancel.

To file a complaint concerning transportation, visit the Grievance section on page 52.

Emergency

If you need emergency transportation, call **911**.

Urgent Care and After-Hours Care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations, and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office. You may need to see a different provider when your PCP's office is closed. You can call your PCP for non-emergency medical problems. Your PCP's office may have suggestions about after-hours care.

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 12 months for those 20 years old and younger.
- One eye exam every 24 months for those 21 years old and over.
- One pair of glasses every 12 months for those 20 years old and younger.
- One pair of glasses every 24 months for those 21 years and over.
- Contact lenses [may require PA] or an eye exam.

You do not need a referral to get eye care. If you need glasses or an eye exam, call Member Services at **1-888-437-0606** (TTY/TDD: **711**). You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Cost Sharing and Copayments

A copayment (sometimes called a "copay") is a set dollar amount that you are required to pay as your share of the cost for a medical service or supply. Meridian does not require you to pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan.

You must go to a doctor in the Meridian Medicaid network, unless otherwise approved. If you go to a doctor that is not in the Meridian Medicaid network and did not get approval to do so, you may have to pay for those services. You should not get a bill from your doctor for covered services within the plan's network. If you have questions about how copays may apply to you, contact Member Services at **1-888-437-0606** (TTY/TDD: **711**).

Services Covered by Medicaid not Meridian

Meridian does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at 1-800-642-3195.

- Services provided by a school district and billed through the Intermediate School District.
- Inpatient hospital psychiatric services.
- Outpatient partial hospitalization psychiatric care.
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days).
- Behavioral health services for enrollees meeting the guidelines under Medicaid's policy for serious mental illness or severe emotional disturbance.
- Substance abuse care including:
  - Screening and assessment
  - Detox
  - Intensive outpatient counseling
  - Other outpatient care
  - Methadone treatment

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, call Member Services at **1-888-437-0606**.

Non-Covered Services

- Elective abortions and related services.
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment.
- Elective cosmetic surgery.
- Services for the treatment of infertility.

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your healthcare services.
- Be treated with dignity and respect.
- Receive Culturally and Linguistically Appropriate Services (CLAS).
- Have your personal and medical information kept private.
- Participate in decisions regarding your healthcare, including the right to refuse treatment and express preferences about treatment options.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records, and request those be amended or corrected.
- Be furnished with healthcare services consistent with State and federal regulations.
- Be free to exercise your rights without adversely affecting the way the contractor, providers, or the State treats you.
- File a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act.
- Be free from other discrimination prohibited by State and federal regulations.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand.
- Receive Federally Qualified Health Center and Rural Health Center services.
- To request information regarding provider incentive arrangements including those that cover referral services that place the provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.
- To request information on the structure and operation of the Meridian.
- To make suggestions about our services and providers.
- To make suggestions about member rights and responsibilities policy.
- To request information about our providers, such as license information, how providers are paid by the plan, qualifications, and what services need prior approval.

You have the Responsibility to:

- Review this handbook and Meridian Certificate of Coverage.
- Make and keep appointments with your Meridian doctor.
- Treat doctors and their staff with respect.
- Protect your Medicaid ID cards against misuse.
- Contact us if you suspect fraud, waste, or abuse.
- Give your Health Plan and your doctors as much info about your health as possible.
- Learn about your health status.
- Work with your doctor to set care plans and goals.
- Follow the plans for care that you have agreed upon with your doctor.
- Live a healthy lifestyle.
- Make responsible care decisions.
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes.
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to **newmibridges.michigan.gov/**.

Grievances and Appeals

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

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call Meridian at **1-888-437-0606** (TTY/TDD: **711**).

Grievance Process

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, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. 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. 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 Meridian at 1-888-437-0606 (TTY/TDD: 711). You can also file your grievance in writing via mail or fax at:

Meridian
Grievance Coordinator
P.O. Box 10353
Van Nuys, CA 91410-0353

Fax: **1-833-669-1734**

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, names of the people involved, and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **1-888-437-0606** (TTY/TDD: **711**). We will let you know when we have received your grievance. We may contact you for more information.

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 Meridian in writing with the name of your representative and their contact information. Your grievance will be resolved within 90 calendar days of submission. We will send you a letter of our decision.

Appeal Process

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

- The adverse benefit determination the contractor has made or intends to make.
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- 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/External Review and how to do it.
- Your right in some circumstances to ask for an expedited appeal and how to do it.
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services.

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination.

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

You can file your appeal on the phone by calling Meridian at 1-888-437-0606 (TTY/TDD: 711). You can also file your appeal in writing via mail or fax at 1-833-341-2044:

Meridian
Appeals Specialist
P.O. Box 10353
Van Nuys, CA 91410-0353

You have several options for assistance. You may:

- Call Member Services and we will assist you in the filing process.
- 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.

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 their contact information or, 2) fill out the Michigan Internal Appeal form. You may call and request the form or find this form on our website at **mimeridian.com**.

We will send you a notice 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 30 calendar days of the date we received your appeal request, or within 10 calendar days if you are receiving CSHCS benefits. Meridian may request an extension up to 14 more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

If your appeal was expedited, we will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If Meridian's decision agrees with the Notice of Adverse Benefit Determination, 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 Adverse Benefit Determination, we will approve the services 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 Meridian reviews your appeal

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days (or 10 calendar days for CSHCS members) 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 Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

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 **1-888-437-0606** (TTY/TDD: **711**).

What Happens Next?

After you receive the Notice of Internal Appeal Decision 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 from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an external review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an external review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a Notice of Internal Appeal Decision from us within the required time frame.

Call Meridian at **1-888-437-0606** (TTY/TDD: **711**) if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR, telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at **1-800-648-3397**.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send your request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Or call: **1-877-999-6442**

Fax: **1-517-284-8838**

Online: **https://difs.state.mi.us/Complaints/ExternalReview.aspx**

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your care manager. If you don't have a care manager, and need help please call Member Services at **1-888-437-0606** (TTY/TDD:**711**).

You can also access resources at the following:

- Online through our website: **mimeridian.com**
- Online through the State of Michigan portal: **newmibridges.michigan.gov** where you can apply for many of the public assistance benefits listed below.
- Online through the Michigan 2-1-1 website: **mi211.org**

Cash Assistance (FIP, RCA, SDA): Information on the Family Independence Program, State Disability Assistance, SSI, Refugee, and other cash assistance.

Child Development and Care (CDC): If you cannot afford child care, payment assistance is available.

Developmental Disability: Your local Community Mental Health Services Program (CMHSP) provides help if you or a family member has a developmental disability (cerebral palsy, intellectual disability, autism, challenging or troubling behaviors, or an IQ of 70 or below).

Early On® Program: Offers resources to help children ages 0-3 with special needs. This program is offered through the Michigan Intermediate School Districts (ISDs).

Food Assistance (SNAP/FAP): Information on the Food Assistance Program, eligibility requirements, and other food resources.

Helping Hand: www.michigan.gov/helpinghand

State Emergency Relief/SER (Housing, Utilities, Burial Cost, Weatherization): Information on assistance with home repairs, heat and utility bills, relocation, home ownership, burials, home energy, and eligibility requirements.

Students with Disabilities (ages 3-26): The ISDs provide physical, speech, and occupational therapy services.

Temporary Assistance for Needy Families (TANF): provides grant funds to states and territories to connect families with financial assistance and related support services. State administered programs may include child care assistance, job preparation, and work assistance. To be eligible for this benefit program, applicants must be a resident of Michigan and a U.S. citizen, legal alien, or qualified alien. You must be unemployed or underemployed and have low or very low income. You must also be one of the following:

- Have a child 18 years of age or younger.
- Be pregnant.
- Be 18 years of age or younger and the head of your household.

Women, Infants, and Children (WIC): is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to healthcare. Call **1-800-262-4784** to find a WIC clinic near you or call Member Services for assistance.

Make Your Wishes Known: Advance Directives

Meridian supports your right to file an "Advance Directive" according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don't want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a d*urable power of attorney for healthcare*. There are two kinds of advance directives in Michigan:

Living Will – A living will tells others how you feel about care that continues your life. This kind of care includes:

- The use of dialysis and breathing machines.
- Tube feedings.
- Organ or tissue donation.
- If you want to be saved when your breathing or heartbeat stops.

Durable Power of Attorney for Healthcare – To create one, you will need to choose a patient advocate. This person carries out your wishes and makes decisions for you when you cannot.

It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Member Services or visit our website **mimeridian.com** for more information and the forms you need to write an advance directive.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170

Call: **1-517-241-0205**

Or click below:
https://www.michigan.gov/lara/bureau-list/bpl
Click on *File a Complaint*

If you have complaints about how Meridian follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at **1-877-999-6442** or go to **michigan.gov/difs**.

Help Identify Healthcare Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other healthcare providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. Here are some examples of fraud:

- Using someone else's member ID card.
- Changing a prescription written by a doctor.
- Billing for services that were not provided.
- Billing for the same service more than once.

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from healthcare for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments.
- Doctors ordering excessive or unnecessary testing.
- Mail order pharmacies sending you prescriptions without confirming you still need them.

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- Using the emergency room for non-emergent healthcare reasons.
- Going to more than one doctor to get the same prescription.
- Threatening or offensive behavior at a doctor's office, hospital, or pharmacy.
- Receiving services that are not medically necessary.

You Can Help

We work to find, investigate, and prevent healthcare fraud. You can help. Know what to look for when you get healthcare services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you.
- The type and date of service are the same type and date of service you received.
- The diagnosis on your paperwork is the same as what your doctor told you.

Healthcare fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name. You can report fraud, waste, or abuse to us at:

Meridian
Attn: Fraud, Waste and Abuse Department
777 Woodward Ave, Suite 700
Detroit, MI 48226

Toll-Free: **1-844-667-3560**

Email: **Special_Investigations_Unit@CENTENE.com**

You may also report or get more information about healthcare fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: **1-855-MI-FRAUD (1-855-643-7283)**

Or visit: **michigan.gov/fraud**. Information may be left anonymously.

New Technology

We want to make sure you have access to new health technologies and procedures. You can recommend that we cover new technology. Our providers and clinical staff will research the new technology before it is approved. Any updates that affect you are noted in the Member Newsletter. This information comes from medical professional groups, Medicaid, other government groups, and scientific groups.

Helpful Definitions

Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service.
- A supply or item.
- A prescription drug that you think you should be able to get.

Reduces, limits or denies coverage of:

- A healthcare service.
- A supply or item.
- A prescription drug you already got.

Your plan stops providing or paying for all or part of:

- A service.
- A supply or item.
- A prescription drug you think you still need.

Does not provide timely health services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit.
- Hospital outpatient visit.
- Prescription drug.

Definitions

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment.
- Wheelchairs.
- Crutches.
- Blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

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

Excluded Services: Medical services that your plan doesn't pay for or cover.

Definitions

Formulary: The formulary is a list of drugs that can be used for treatment and to improve health outcomes. The Meridian formulary is created based on the Michigan Single Preferred Drug List (PDL). Meridian uses clinical advice from providers, pharmacists, and other medical experts to create the most up-to-date formulary. The formulary has prescription drugs and some over-the-counter drugs.

The formulary lists drugs that are covered and drugs that need prior authorization. Drugs on the formulary that need prior authorization will require your provider to submit a form. If prior authorization is approved, the drug will be covered. Your provider can fill out a Prior Authorization Request Form and fax it to Meridian at **1-877-355-8070** or submit a web-based Prior Authorization request on **covermymeds.com**.

If a medication is covered or approved, your provider needs to write you a prescription to get it filled at the pharmacy. The formulary is on our website at **mimeridian.com**. Look under "Our Plans," select "Michigan," choose your plan, then select "Members," and formulary information can be found under "Pharmacy." Call **1-866-984-6462** if you want a printed copy.

How can I request a formulary exception?

There are drugs that are not on the formulary. We do not cover or pay for drugs that are not on the formulary unless there is an exception. Some drugs are excluded by the State of Michigan. No exceptions can be made for these drugs.

If a drug does not work for you or the drug makes you sick, your provider can ask for a different drug for your health issues. Your provider will need to fill out a Formulary Exception Form if the new drug is not on the formulary. Your provider can fax the form to Meridian at **1-877-355-8070** or submit a web-based request on **covermymeds.com**. **NOTE:** We must approve the formulary exception before you can fill the prescription from your provider.

Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy.
- Speech-language pathology.
- Services for people with disabilities.

Definitions

Health Insurance: Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medicaid Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- Illness
- Injury
- Condition
- Disease
- Symptom

Definitions

Network: Healthcare providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers healthcare services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

Premium: The amount paid for healthcare benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Definitions

Primary Care Physician: A licensed physician who provides and manages your healthcare services. (See Primary Care Provider.)

Primary Care Provider (PCP): A licensed physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides and manages your healthcare services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place, or group that's licensed to provide healthcare, like doctors, nurses, and hospitals.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy.
- Speech-language pathology.
- Psychiatric rehabilitation services.

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

Specialist: A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

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

Effective 5/2/2024

For help to translate or understand this, please call **1-888-437-0606** (TTY: **711**).

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-888-437-0606** (TTY: **711**).

Covered Entity's Duties:

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

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

Meridian reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Meridian will promptly revise and distribute this Notice whenever there is a material change to the following:

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

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

Internal Protections of Oral, Written, and Electronic PHI:

Meridian protects your PHI. We are also committed in keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.

- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

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

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

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

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

Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with healthcare providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services.

This information helps us to:

- Better understand your healthcare needs.
- Know your language preference when seeing healthcare providers.
- Providing healthcare information to meet your care needs.
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

- ***Group Health Plan/Plan Sponsor Disclosures*** — We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a healthcare program to you, if the

sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

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

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

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

Individuals Rights

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

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

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

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

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

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

Contact Information

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

Meridian
Attn: Privacy Official
777 Woodward Ave, Suite 700
Detroit, MI 48226
1-888-437-0606 (TTY: 711)

Notice of Non-Discrimination

Meridian complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Meridian does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Meridian:

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

If you need these services, contact Meridian Member Services.

If you believe that Meridian has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with our 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 1557 Coordinator is available to help you.

Mail: 1557 Coordinator
P.O. Box 31384
Tampa, FL 33631
Telephone: **1-855-577-8234** (TTY users should call **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

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

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

This notice is available at Meridian website:
https://www.mimeridian.com/members/medicaid/resources/faqs.html

English: This information is also available for free in other languages and formats like Braille or audio CD. Call **1-888-437-0606** (TTY/TDY: **711**).

Español (Spanish): Esta información también está disponible de manera gratuita en otros idiomas y formatos como Braille o CD de audio. Llame al **1-888-437-0606** (TTY/TDY: **711**).

العربية (Arabic): تتوفر أيضًا هذه المعلومات مجانًا بلغات وتنسيقات أخرى مثل برايل أو أقراص. مدمجة صوتية. اتصل على الرقم **1-888-437-0606** (TTY/TDY: **711**).

中文 (Chinese): 此資訊也可免費提供其他語言版本和格式，例如點字版或語音 CD。請致電 **1-888-437-0606** (TTY/TDY：**711**)。

Tagalog (Tagalog): Available din ang impormasyong ito nang libre sa iba pang wika at format gaya ng Braille o audio CD. Tumawag sa **1-888-437-0606** (TTY/TDY: **711**).

Tiếng Việt (Vietnamese): Thông tin này cũng được cung cấp miễn phí bằng các ngôn ngữ và định dạng khác như chữ nổi Braille hoặc CD âm thanh. Gọi số **1-888-437-0606** (TTY/TDY: **711**).

Deutsch (German): Diese Informationen sind auch kostenlos in anderen Sprachen und Formaten verfügbar, wie z. B. in Braille-Schrift oder als Audio-CD. Sie erreichen uns unter: **1-888-437-0606** (TTY/TDY: **711**).

한국어 (Korean): 이 정보는 다른 언어 및 점자 또는 오디오 CD와 같은 형식으로도 무료로 제공됩니다. **1-888-437-0606** (TTY/TDY: **711**) 번으로 전화해 주십시오.

Русский (Russian): Эта информация также бесплатно доступна на других языках и в других форматах, таких как шрифт Брайля или CD с аудиофайлами. Позвоните по номеру **1-888-437-0606** (TTY/TDY: **711**).

Italiano (Italian): Queste informazioni sono disponibili gratuitamente anche in altre lingue e formati come Braille o CD audio. Chiamare il numero **1-888-437-0606** (TTY/TDY: **711**).

Polski (Polish): Informacje te są również dostępne bezpłatnie w innych językach lub formatach, np. zapisane alfabetem Braille'a czy w formie nagrania audio na płycie CD. Należy zadzwonić pod numer **1-888-437-0606** (TTY/TDY: **711**).

Shqip (Albanian): Ky informacion disponohet gjithashtu pa pagesë në gjuhë dhe formate të tjera si breil ose audio CD. Telefononi në numrin **1-888-437-0606** (TTY/TDY: **711**).

বাংলা (Bengali): এই তথ্যটি ব্রেইল বা অডিও CD-র মতো অন্যান্য ভাষা ও ফর্ম্যাটে বিনামূল্যে উপলব্ধ। **1-888-437-0606** (TTY/TDY: **711**)-এ কল করুন।

日本語 (Japanese): この情報は、他の言語、または点字やオーディオ CD などの他の形式でも無料で入手できます。**1-888-437-0606**（TTY/TDY：**711**）までお電話ください。

Srpski (Serbian and Croatian): ove informacije su dostupne i besplatno na drugim jezicima i u drugim formatima poput Brajevog pisma ili audio CD-a. Pozovite **1-888-437-0606** (TTY/TDY: **711**).

ܣܘܪܝܝܐ (Syriac): ܐܗܐ ܡܘܕܥܢܘܬܐ ܡܫܬܟܚܢܬܐ ܝܠܗ̇ ܒܠܫܢܐ ܘܦܘܪܡܛܐ ܐܚܪܢܐ ܐܝܟ ܠܫܢܐ ܕܒܪܝܠ ܘܦܩܐܠ ܐܘ ܣܝܕܝ. ܩܪܝ ܡܢܝܢ ܠ **1-888-437-0606** (TTY/TDY: **711**).

CAD_166750E_ Internal Approved 09132024

MI4CADINS66750E_0824
MI_CAID_NDN


meridian