



— ILLINOIS —

MEMBER HANDBOOK





WELCOME TO HARMONY HEALTH PLAN

INTRO TO PLAN:

We want to give you and your family the quality health care and respect you deserve. Harmony Health Plan is for families who are in an Illinois Medical Assistance Program. You'll have 24-hour access to a wide range of care and services at provider offices close to you. This is at no cost to you.

This handbook tells you more about your benefits. We hope to answer most of your questions.

You can get materials in large print, audiotapes and Braille upon request. We can also arrange services for visual- or hearing-impaired members. Call **1-800-608-8158** (TTY **1-877-650-0952**) weekdays. We're here for you from 8 a.m. to 5 p.m.

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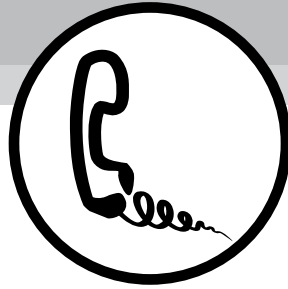
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IMPORTANT PHONE NUMBERS

Important Phone Numbers and Contacts

Phone Numbers:

Harmony Member Services	1-800-608-8158 (TTY 1-877-650-0952)
Harmony Transportation Hotline	1-800-608-8158
Harmony Hugs Program	1-866-776-9876
24-Hour Nurse Advice Line	1-800-919-8807
Behavioral Health Crisis Line	1-855-591-7135
Behavioral Health Mobile Crisis Response Services for Children (CARES)	1-800-345-9049

Website Address:

www.harmonyhpi.com

Service Area:

Our service area includes all counties in Illinois.

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MEMBER SERVICES

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MEMBER SERVICES:

Welcome to Harmony Health Plan

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

Harmony Member Services.....**1-800-608-8158** (TTY **1-877-650-0952**)

We are here to help weekdays, 8 a.m. to 5 p.m. You can also call the Nurse Advice Line 24 hours a day at **1-800-919-8807**.

Member Services can answer your questions about our plan and help you learn more about your benefits and services. We have friendly staff trained to answer your questions. Call Member Services to get help with finding a provider, choosing or changing your PCP, or requesting printed materials. Our team can also help you file a complaint and answer any other questions you might have about our plan.


Member Identification (ID) Card:

You will receive a Member ID Card. You should always carry your card with you. It has important phone numbers. You will need to show it when you get services.

Information on your Member ID Card:

- Name
- Plan Name
- State Medicaid ID #
- PCP information (name, address, phone number)
- Effective Date
- Member Services #
- 24 hour Nurse Hot Line
- Behavioral health #
- Dental #
- Transportation #
- Rx , Rxbin, Rxgroup, (this information helps your providers with billing)
- Name & Address of MCO
- Claims Address for Providers to send claims

MEMBER SERVICES

 <p>An Illinois Licensed Health Maintenance Organization (HMO)</p> <p>Member Name: JANE SMITH Member #: 12345678 DOB: 07/04/1990 EFF Date: 01/01/2018 Member RIN #: 87654321</p> <p>Your Personal Doctor: ROBERT JONES, M.D. Doctor's Address: 50 N UPPER WACKER DR. CHICAGO, IL 60606</p> <p>Your Doctor's Phone: 312-123-4567 Medical Group Name: CHICAGO PHYSICIANS GROUP</p> <p>OV: \$1.00 ER: \$1.00 MH: \$1.00 RX: \$1.00/\$2.00 RxBIN: 4336 RxPCN: 123456 RxGRP: MEDDAV</p>	<p>www.harmonyhpi.com For emergencies, go to the nearest ER or call 911. Contact your primary care provider as soon as possible.</p> <p>Customer Service: 1-800-608-8158 / TTY 1-877-650-0952 24-Hour Nurse Line: 1-800-919-8807 Behavioral Health Crisis Line: 1-855-591-7135 Dental/Transportation: 1-800-608-8158 Harmony Hugs: 1-866-776-9876 Hospital Prior Authorization: 1-800-504-2766 CommUnity Assistance Line: 1-866-775-2192</p> <hr/> <p>Harmony Health Plan P.O. Box 31370 Tampa, FL 33631-3370</p> <p>Medical claims are to be mailed to: Harmony Health Plan P.O. Box 31372 Tampa, FL 33631-3372 1-800-608-8158 24 hours a day, 7 days a week</p>
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Open Enrollment:

Once each year, you can change health plans during a specific time called “Open Enrollment”. Client Enrollment Services (CES) will send you an open enrollment letter approximately 60 days prior to your anniversary date. Your anniversary date is one year from your health plan start date. You will have 60 days during your open enrollment to make a one plan switch by calling CES at **1-877-912-8880**. After the 60 days has ended, whether a plan switch was made or not, you will be locked in for 12 months. If you have questions regarding your enrollment or disenrollment with *Harmony* please contact the Client Enrollment Service (CES) at **1-877-912-8880**.

Provider Network:

A Provider Network is a group of providers that work with Harmony to give you care. These providers include doctors, hospitals, pharmacies, laboratories and other medical professionals. You may choose any providers in our network.

Primary Care Provider (PCP):

Your primary care provider is your personal doctor who will give you most of your care. They may also send you to other providers if you need special care. With Harmony, you can pick your PCP. You can have one PCP for your whole family or you can choose other PCPs for each family member.

You may have chronic health conditions, disabilities or special health care needs. If so, you can ask us to pick a specialist as your PCP. Call Member Services at **1-800-608-8158** (TTY **1-877-650-0952**).

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

If you need help in finding or changing your PCP, please contact Member Services at **1-800-608-8158** (TTY **1-877-650-0952**). We are here to help weekdays, 8 a.m. to 5 p.m.

How to Change PCPs:

You can change your PCP at any time. Please contact Member Services at **1-800-608-8158** (TTY **1-877-650-0952**). We are here to help weekdays, 8 a.m. to 5 p.m.

Women's Health Care Provider (WHCP):

As a woman with Harmony coverage, you have the right to select a Women's Health Care Provider (WHCP). A WHCP is a doctor licensed to practice medicine specializing in obstetrics, gynecology or family medicine.

Family Planning:

Harmony has a network of Family Planning providers where you can get family planning services; however, you may choose to get family planning services and supplies from any out of network provider without a referral and it will be covered.

Specialty Care:

A Specialist is a doctor who cares for you for a certain health condition. An example of a Specialist is Cardiology (heart health), Orthopedics (bones and joints). If your PCP thinks you need a specialist, he or she will work with you to choose a specialist. Your PCP will arrange your specialty care. You must see or call your PCP first. Your PCP will arrange for you to see a specialist when you need one. If you see a specialist on a regular basis, you can ask for a standing referral. That lets you to go to the specialist without a referral from your PCP each time.

If you have any questions about a referral, call your PCP. You can also call Member Services at **1-800-608-8158** (TTY **1-877-650-0952**).

Scheduling Appointments:

It is very important that you keep all appointments you make for doctor visits, lab

test, or X-rays. Please call your PCP at least one day ahead of time if you cannot keep an appointment. If you need help in making an appointment, please contact Members Services at **1-800-608-8158** (TTY **1-877-650-0952**). We are here to help weekdays, 8 a.m. to 5 p.m.

Urgent Care:

Urgent care is an issue that needs care right away but is not life threatening.

Some examples of urgent care are:

- Minor Cuts and scrapes
- Colds
- Fever
- Ear ache

Call your Doctor for urgent care or you can call Harmony Member Services at **1-800-608-8158** (TTY **1-877-650-0952**). We are here to help weekdays, 8 a.m. to 5 p.m.

Emergency Care:

An emergency medical condition is very serious. It could even be life threatening. You could have severe pain, injury or illness.

Some examples of an emergency are:

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

What to do in case of an Emergency:

- Go to the nearest Emergency Department; you can use any hospital or other setting to get emergency services
- Call **911**
- Call ambulance if no **911** service in area
- No referral is needed
- Prior authorization is not needed, but you should call us within 24 hours of your emergency care.

Post-Stabilization Care:

Post-Stabilization Services are needed services given to an Enrollee once the Enrollee is stabilized following an emergency medical condition, in order to make the Enrollee better.

You can find facilities providing post-stabilization services in your Provider Directory. Or, contact Member Services at **1-800-608-8158 (TTY 1-877-650-0952)** for more information. Medically Necessary Post-Stabilization Medical Services provided by a non-participating provider are covered 100% when these conditions are met:

- The non-participating provider has approval to provide the services from the Health Plan; or
- The non-participating provider made two (2) good faith attempts to contact the Health Plan and the Health Plan did not respond or deny the services within one (1) hour of the non-participating provider's attempt to contact the Health Plan

Covered Services:

Your PCP will arrange your health care. They will do your checkups. They will treat you for most of your health needs. If you need it, your PCP will send you to other specialists. Or admit you to the hospital.

You can call your PCP's office. You will find their name and phone number on your ID card. You can even call the office after hours. An on-call doctor can help you.

Covered Medical Services:

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

- Advanced Practice Nurse services;
- Ambulatory Surgical Treatment Center services;
- Assistive/Augmentative communication devices;
- Audiology services;
- Blood, blood components and the administration thereof;
- Chiropractic services for Enrollees under age twenty-one (21);
- Dental services, including oral surgeons;
- EPSDT services for Enrollees under age twenty-one (21);

- Family Planning services and supplies;
- FQHCs, RHCs and other Encounter rate clinic visits;
- Home health agency visits;
- Hospital Emergency Department visits;
- Hospital inpatient services; Hospital ambulatory services;
- Laboratory and x-ray services;
- Medical supplies, equipment, prostheses and orthoses;
- Mental health services;
- Nursing care;
- Nursing Facility services;
- Optical services and supplies;
- Optometrist services;
- Palliative and Hospice services;
- Pharmacy services;
- Physical, Occupational and Speech Therapy services;
- Physician services;
- Podiatric services;
- Post-Stabilization services;
- Renal Dialysis services;
- Respiratory Equipment and supplies;
- Services to prevent illness and promote health;
- Subacute alcoholism and substance abuse service;
- Transplants;
- Transportation to secure Covered services.

Behavioral Health Care

Your mental health or behavioral health is part of staying healthy. If you have any of the issues listed below, call us. We will give you the names and phone numbers of providers who can help. (You can search for a provider on our website too. Log on to www.harmonyhpi.com). You don't need prior authorization or a referral from your PCP.

If you have any of the feelings or concerns below, call **1-800-608-8158** (TTY **1-877-650-0952**). You will be given a choice of behavioral health providers. We will help you find one in your area.

- Always feeling sad
- Being upset
- Drug or alcohol problems
- Feeling hopeless and/or helpless
- Feelings of guilt or worthlessness
- Loss of interest in the things you like
- No appetite
- Problems paying attention
- Problems sleeping
- Unexplained weight loss or gain
- Your head, stomach or back hurts, and your doctor hasn't found a cause

24-Hour Behavioral Health Crisis Line

We have a 24-hour crisis line. If you think you or a family member is having a behavioral health crisis, call this number. A trained person will listen to you. They will help you decide the best way to handle the crisis.



**24-Hour Behavioral
Health Crisis Line**
toll-free number:
1-855-591-7135

Mobile Crisis Response Services for Children 20 and Younger

SASS stands for Screening, Assessment and Support Services. This program serves children and youths having a mental health crisis and who may need to stay in a hospital for mental health care.

The service is available by calling the CARES line at the number below. Call when a child is at risk to himself or others, and anytime you believe a child is having a mental health crisis.

CARES
1-800-345-9049
(TTY) **1-866-794-0374**

What Is the Purpose of CARES?

CARES links parents, caregivers or callers to the SASS program. Someone on the CARES line will ask questions about the child's behavior. Then CARES will either send a local SASS staff member to see you and your child, or refer you to mental health or other services.

Who Can Get SASS Services?

Any child or youth in a mental health crisis who may need public funding may get SASS services. If you are unsure if your child can receive SASS services, please call CARES at **1-800-345-9049**. TTY users may call **1-866-794-0374**.

Who Provides SASS in My Area?

An agency that provides mental health services in your community is your SASS agency. Agency staff are mental health professionals trained to serve children and youths. Call CARES if you think a child needs SASS services.

What Can I Expect From SASS?

- A SASS crisis worker will come to talk with you and your child.
- The crisis worker will help you make the best plan for your child and family.
- SASS will work with you and your child for at least 90 days.
- If your child goes into the hospital, SASS will join the hospital team to care for your child.
- SASS will help the hospital team plan for your child's return home and will provide services when your child is at home.
- If your child does not go into the hospital, SASS will provide mental health services and support to help your child stay at home.

How Will I Be Involved in My Child's Care?

You play a major role in making a plan for your child's treatment. SASS will work closely with you to show you how to see your child's problems and strengths.

What if I Have Questions?

It is important that you understand what is happening to your child. If you have questions you should ask:

- Your SASS worker
- A member of your Hospital Team
- Your Family Resource Developer

Covered Home and Community Based Services (Waiver clients only):

Here is a list of some of the medical services and benefits that Harmony covers for members who are in a Home and Community Based service waiver.

Department on Aging (DoA), Persons who are Elderly:

- Adult Day service;
- Adult Day service Transportation;
- Homemaker;
- Personal Emergency Response System (PERS);

Department of Rehabilitative Services (DRS), *Persons with Disabilities, HIV/AIDS:*

- Adult Day service;
- Adult Day service Transportation
- Environmental Accessibility Adaptations-Home;
- Home Health Aide;
- Nursing Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;
- Home Health Aide;
- Physical Therapy;
- Speech Therapy;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);
- Respite;
- Specialized Medical Equipment and Supplies;

Department of Rehabilitative Services (DRS), *Persons with Brain Injury:*

- Adult Day service;
- Adult Day service Transportation;
- Environmental accessibility Adaptations-Home;
- Supported Employment;
- Home Health Aide;
- Nursing, Intermittent;
- Skilled Nursing (RN and LPN);
- Occupational Therapy;
- Physical Therapy;
- Speech Therapy;
- Prevocational Services;
- Habilitation-Day;
- Homemaker;
- Home Delivered Meals;
- Personal Assistant;
- Personal Emergency Response System (PERS);

- Respite;
- Specialized Medical Equipment and Supplies;
- Behavioral Services (M.A. and PH.D.)

HealthCare and Family Services (HFS), *Supportive Living Facility*:

- Assisted Living

Managed Long Term Support & Services (MLTSS) Covered Services:

MLTSS Covered Services include:

- Mental health services like: Group and Individual Therapy, Counseling, Community Treatment, Medication Monitoring and more
- Alcohol and substance use services like: Group and Individual therapy, Counseling, Rehabilitation, Methadone services, Medication Monitoring and more
- Some transportation services to appointments
- Long Term Care services in skilled and intermediate facilities
- All Home and Community Based Waiver Services like the ones listed above under 'Covered HCBS Services' if you qualify

Limited Covered Services:

- Abortion services where necessary to protect the health or life of the pregnant woman, or in cases of rape or incest.
- Health plan may provide sterilization services only as allowed by State and federal law.
- If Health plan provides a hysterectomy, Health plan shall complete HFS Form 1977 and file the completed form in the Enrollee's medical record.

Non-Covered Services:

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

- Services that are experimental or investigational in nature;
- Services that are provided by a non-Network Provider and not authorized by your Health Plan

- Services that are provided without a required referral or required prior authorization;
- Elective cosmetic surgery
- Infertility care
- Any service that is not medically necessary
- Services provided through local education agencies

For additional information on services, please contact Member Services at **1-800-608-8158** (TTY **1-877-650-0952**). We are here to help weekdays, 8 a.m. to 5 p.m.

Dental Services:

Dental Care for Adults:

- Comprehensive oral examination – 1 per lifetime per provider or location
- Cleanings – 1 every 6 months
- Dentures – 1 denture every 10 years
- Crowns – 1 every 8 years per tooth
- Bitewings – 1 per 12 months per provider or location
- Fillings – 1 per 12 months per patient per tooth
- Anterior root canal – 1 per lifetime per patient per tooth
- Extractions as required

Added Dental Benefits for Adults:

FREE cleanings every 6 months for members 21 and older, with no co-pay

Dental Care for Children:

- Periodic oral evaluation
- Comprehensive oral examination
- Intraoral (including bitewings)
- Cleaning
- Topical application of fluoride
- Topical fluoride varnish
- Sealant
- Dentures
- Space maintainer
- Crowns
- Bitewings
- Fillings
- Anterior root canal
- Periodontal scaling and root planing
- Orthodontic treatment
- Extractions

Vision Services:

- Optical services and supplies
- Optometrist services

Added Vision Benefit for Adults:

- Vision – **FREE** pair of approved glasses for members 21 and over.

Pharmacy Services:

Prescriptions must come from one of our network providers. You can fill them at any network pharmacy. Our Provider Directory has all of the pharmacies in our plan. You can search for one using the Find a Provider search tool on our website. Member Services can help you find one, too. Call **1-800-608-8158** (TTY **1-877-650-0952**).

At the pharmacy, you'll need to show your Harmony ID card. Brand-name drugs and over-the-counter drugs that we cover may have a co-pay. Please see the Cost Sharing section to learn more. Here's a co-pay guide:

Prescription Item	Co-Pay Amount	Co-Pay Details
Generic drugs	\$2	<p>There are no co-pays for these members for any prescription items:</p> <ul style="list-style-type: none"> Children under 19 covered under Title 19 All Kids Assist Native Americans and Native Alaskans Pregnant women. This includes a 60-day postpartum period Hospice patients Non-institutionalized individuals. Their care is subsidized by the Department of Children and Family Services or the Department of Corrections Individuals enrolled in the Health Benefits for Persons with Breast or Cervical Cancer Program <p>People living in:</p> <ul style="list-style-type: none"> • Nursing homes • Intermediate care facilities for the developmentally disabled • Supportive living facilities <p>People living in a residential care program that is:</p> <ul style="list-style-type: none"> • State-certified, • State-licensed, or • State-contracted
Over-the-counter drugs	\$2 with a prescription	
Brand-name drugs	\$3.90	

Don't forget to ask about generic drugs. These work the same as brand-name drugs. They have the same active ingredients. But they cost less. (Sometimes, your provider may have to ask us to approve a brand-name drug if there is a generic available.)

Preferred Drug List

We have a Preferred Drug List (PDL). This is a list of drugs put together by doctors and pharmacists. Our network providers use this list when they prescribe a drug for you. To see our PDL, go to our website at www.harmonyhpi.com and click on the Harmony logo, then choose Pharmacy Services. There, you also will find tools and links to help you get the most from your drug coverage.

The PDL will include drugs that may have certain requirements, like:

- Prior authorization (PA)
- Step therapy
- Quantity limits
- Age or gender limits

For drugs that need a PA (and those not on our PDL), your provider will need to send us a Coverage Determination Request (CDR). You can also get a 72-hour supply of any drug (on or not on our PDL) that needs a PA.

There are some drugs we will not cover. They include:

- Those used for eating problems or weight gain or weight loss
- Those used to help you get pregnant
- Those used for erectile dysfunction
- Those that are for cosmetic purposes or to help you grow hair
- Drug Efficacy Study Implementation (DESI) drugs and drugs that are identical, related or similar to such drugs
- Investigational or experimental drugs
- Those used for any purpose that is not medically accepted

Can I get any drug I want?

You will get all drugs that are medically necessary. All drugs your providers prescribe for you may be covered if they are on our PDL. You may have to get pre-approval if your provider prescribes certain drugs. (This includes drugs for mental health and substance abuse treatment.) In some cases, we may ask you to try another drug before we approve the one you first asked for.

Over-the-Counter (OTC) Drugs

Harmony pays for some OTC drugs. In some cases, you may have a \$2 co-pay. All OTC drugs covered on our plan must have a prescription. Some of the OTC drugs the plan pays for include:

- Aspirin
- Ibuprofen
- Diphenhydramine
- Non-sedating antihistamines such as cetirizine
- Insulin and insulin syringes
- Urine test strips
- Topical antifungals such as clotrimazole
- Antacids such as aluminum hydroxide
- H-2 receptor antagonists such as ranitidine
- Proton pump inhibitors such as omeprazole
- Multivitamins/multivitamins with iron
- Iron

See our PDL for a list of all covered OTC drugs. Call Member Services with questions you have about this.

HARMONY +10 Personal Care Items

You can get some personal care items mailed to your home. (Products will be generics. The list of items you can get may change.) The booklet you received with your welcome packet lists the items. Every month you can choose the items you want. You can choose up to \$10 in products for your home. Place your order with Member Services at **1-800-608-8158** (TTY **1-877-650-0952**).

Your order will be shipped to you within 10 business days. Any unused portion of your benefit does not carry over to the next month. You can also order online. Simply go to www.harmonyhpi.com for details.

Transportation Services:

Harmony offers transportation to any medical, pharmacy or dental visit.

Harmony also offers rides to:

- Women, Infants, and Children (WIC) offices
- Durable medical equipment visits
- Visits to family members in the hospital
- Children, including siblings, may ride with the member

You can call **1-800-608-8158** (TTY **1-877-650-0952**). Please call at least 48 hours in advance.

Added Benefits:

Extra benefits include:

CommUnity Assistance Line

We offer a **FREE** CommUnity Assistance Line (CAL) in Illinois to all Harmony members. Anyone can call, not just members. This includes those who are deaf or hearing-impaired. By calling the CAL, you can learn about programs and social services in your area. They will connect you to things like:

- Utility help
- Food banks
- Transportation
- Rental help
- Free and reduced-cost child care

You can call the CAL toll-free at **1-866-775-2192**. You can call Monday–Friday, from 8 a.m. to 5 p.m. Central. Deaf or hearing-impaired people can get video relay chat. Call **1-855-628-7552** Monday–Friday, from 8 a.m. to 5 p.m. Central.

Prenatal

- Harmony Hugs – Prenatal Care Management Program that:
 - stays in touch with members during their pregnancy
 - helps with making doctor appointments
 - gives you educational materials about pregnancy and baby care
 - gives a **FREE** diaper bag and nursery kit to pregnant members in the program
- Prenatal Rewards Program – **FREE** choice of baby stroller or portable play yard. You must be enrolled in the Hugs Program. You must go to 6 prenatal doctor visits.

Steps2Success

This program gives you ways to advance in the areas of education, employment, and finances.

- **FREE** job training and financial education classes
- **FREE** reading scholarships for members in pre-kindergarten through 5th grade who want to improve their reading skills

- **FREE** GED® Exams for:
 - members age 16 and older,
 - not currently enrolled in high school,
 - not a graduate from an accredited high school, and
 - have not received a high school equivalency certificate or diploma.

You must take the required GED courses at an adult testing center. This helps make sure that you pass the test.

Wellness

- **Dental**
 - Extra dental care for adults
 - **FREE** cleanings every 6 months for members 21 and older, with no co-pay
- **Healthy Kids Club** – **FREE** program that gives health tips and tools to kids ages 4–11 to encourage getting shots and checkups
- **Harmony +10** – Get \$10 in **FREE** over-the-counter (OTC) items each month. That's \$120 a year! You can order items like sunscreen, aspirin and more. We will mail them right to your home.
- **Vision** – **FREE** pair of approved glasses for members 21 and over.
- **Free 3-month membership to Curves®** for qualified Harmony members. You can even make your Curves membership last longer with the approval of a Health Coach. You can:
 - Take part in the Curves Complete® Program
 - Join a 30-minute fitness program
 - Get one-on-one help from a nutritionist
 - Get help making shopping lists and recipes
 - Get tips to boost your health and help you make better lifestyle choices
- **Anytime Fitness discounts:** Harmony members and their immediate family are eligible to enjoy these items at participating Anytime Fitness clubs:
 - 10% off standard monthly dues
 - 50% off standard enrollment

For a list of club locations, visit www.anytimefitness.com.

MEMBER SERVICES

- **LA Fitness® discounts:** Harmony members and their immediate family* can get the discounted rate each month per person. There is no joining fee. When you become a member, you can go to all LA Fitness clubs (except Signature). You must pay the first and last month's membership fee. You will get:
 - Strength and cardio equipment
 - Strength and free weight centers
 - Group fitness classes – any class, any time
 - Personal training*
 - Pool, sauna and aqua fitness classes*
 - Basketball and volleyball*
 - Racquetball*
 - Sports leagues*
 - Kids Klub – babysitting*
 - Juice bars*
 - And more!

*Amenities and classes may vary from club to club. There is an extra charge for some of these items. Family members must live at the same address as the member. Family memberships must be paid for with the same account as the primary member's membership.

- **Healthy Rewards Program** – Members who complete a qualified healthy activity get a reloadable Visa debit card or gift card.
- **Diaper Program** – Get up to 6 packs of diapers. Just go to the postpartum visit and get all of your baby's shots.
- **FREE** hypoallergenic bedding for qualified members
- **Nurse Advice Line** – Health advice 24 hours a day, 7 days a week. Call **1-800-919-8807**.
- **FREE Cell Phone** – You get a free cell phone if you have a high-risk pregnancy and are in a Care Management Program. You must not already have a phone. You get unlimited text messaging. You also get programmed numbers for your provider, care manager and social worker.
- **Adaptive Devices** – If you qualify, you can get items to help you with your daily activities in your home.
- **COBALT** – You get free online therapy for many mental health conditions. This is private.
- **Community Paramedics** – If you qualify, you get health education, monitoring and services from your local EMT service.

Other Additional Benefits

- **Community Rooms** – You can get support for things like help with benefit applications, help with transportation, and community support.
- **In-Home Durable Medical Equipment (DME) Evaluation** – If you qualify, you can get a visit from a licensed physical therapist to do an evaluation for DME in your home.
- **Meals Program** – If you qualify, you can get 10 meals for nutrition when you go home from an inpatient stay. This means a stay at a hospital, skilled nursing facility or inpatient rehabilitation facility. This happens within 2 weeks from your discharge.
- **Parent Support and Training** – This is for parents/families of qualified members 18 and under who have serious emotional issues and are at-risk for being placed outside the home. They get training and support to make sure they participate in a treatment plan.
- **Peer Support** – You get support and coaching. This is especially for those on medication.
- **Respite (Relief Camps)** – You get respite days/hours and places to find services. This is for those who qualify.
- **Online Communities** – You can go to an online place where you can talk about local events, health topics and community services.
- **Welcome Home Kit** – If you qualify, you get this when you are going from a foster home or nursing home to your home or another private home.
- **Mobile App** – Provides members with easy access to their member ID card, Find-a-Provider tool, Quick Care (urgent care/hospital services locator), Contact Us and wellness services.
- **Free Safelink Cell Phone** – Qualified members can get a free cell phone with 350 minutes each month and unlimited texts.
- **Pill Packaging** – Members who are homebound or in rural areas may receive the option of utilizing the mail order pharmacy.
- **Supplemental Transportation** – Covers the cost to reimburse families and friends who provide supplemental transportation to members to their doctor appointments.
- **Physician Home Visit** – Qualified members can have a physician visit your home for checkups and other medical services.
- **Direct Support Training** – Direct support workers assigned to members can access training to obtain or keep their certification.
- **Transitional Support Funding** – Qualified members can get funds to aid in the transition from a nursing home into a private home setting.

Harmony Diaper Program

Get up to 6 packs of diapers by:

- Going to your postpartum doctor visit
- Getting baby's recommended shots

Here's a list of the basic doctor visits you and your baby need. After each visit, we'll send you a free pack of diapers. After all 5 visits, you can get another pack of diapers.

Checkups recommended for you and your baby:

- 6-week postpartum checkup
- 1-month checkup
- 2-month checkup
- 4-month checkup
- 6-month checkup

Once you get your Diaper Rewards package in the mail, just follow these steps:

- Ask the doctor to sign a postcard at each visit. You and your baby must be Harmony members at the time of their checkup.
- Write your name, member ID number and home address on the postcard. Then mail it back to us. You do not need a stamp.

We'll send you a free pack of diapers for each completed postcard you send us.

When we get all 5 postcards back from you, we'll send you an extra pack of diapers.

New Member – Transition of Care

You may be in treatment with a provider who is not in Harmony's network. You can ask to keep seeing that provider for up to 90 days after you become a member. You must meet these conditions:

- You must keep seeing the same provider to get treated for the condition or disease.
- You are in your seventh, eighth or ninth month of pregnancy. You can ask to keep your provider until after your baby is born and all follow-up care is done.
- Your provider agrees to follow the plan's rules and payment.
- You are transitioning from pediatric care to adult care.

You must ask for this in writing. Call Member Services for help. We will let you know in writing within 15 days if we approve or deny. We will also let you know the reason.

MEMBER SERVICES

- Visits in conjunction with the Early Intervention Program
- Visits scheduled for well–baby care, well–child care, or age appropriate immunizations
- Visits to health care professionals or hospitals made solely for radiology or laboratory services

Co-pays, if above exclusions are not applicable:

Benefit	Co-Pay
Specialist Office Visits	\$3.90/visit
Physician Consultation	\$3.90/visit
Psychiatrist	\$3.90/visit
Ophthalmology	\$3.90/visit
Medical or Dental Encounter – Clinic Visit	\$3.90/visit
Behavioral Health Encounter – Clinic Visit	\$3.90/visit
Restorative Dental Visits	\$3.90/visit
Generic Prescriptions	\$2
Brand Name Prescriptions	\$3.90
Over-the-Counter Drugs (doctor’s prescription required)	\$2
Hospital Inpatient Services (including substance abuse and mental health services)	\$3.90/day
Emergency Room Visit for Non-emergent Service	\$3.90/visit

Care Coordination:

Harmony offers care management services to children and adults who have special health care needs. Our care management programs are offered to members who:

- Are identified as needing help getting or using services
- Have long-term complex health conditions like asthma, diabetes, heart disease and high-risk pregnancy
- Have complex health conditions, including members who are elderly, brain-injured, disabled, have HIV/AIDS, are in Long Term Care or have supportive living services

Our Care Management Program can help you and your family with your health care needs. That includes referrals for special care you may need for your illness. Our goal is to help you take care of yourself and stay healthy.

You'll have a care manager and other outreach workers. They'll work one-on-one with you to manage your care. To do this, they:

- May ask you questions to get more information about your condition
- Will work with your PCP to get services you need and help you understand your illness
- Will give you information to help you understand how to take care of yourself and how to get services, including local resources

You may be contacted about care management if:

- You ask for these services
- Your PCP asks that you be placed into a Care Management Program
- We feel you meet the requirements for one of our care management programs

Talk with your PCP about this. Or call Member Services to learn more.
Call **1-800-608-8158** (TTY **1-877-650-0952**).

Disease/Health Education Management Programs:

Nurse Advice Line

You can call **1-800-919-8807** 24/7, any day of the year. This is at no cost. Call any time someone in your family is sick or hurt or needs medical advice. You will get friendly,

helpful advice. The nurse will ask about your problem. Tell the nurse where it hurts, what it looks like, and what it feels like. The nurse can help you decide if you need to:

- Go to the hospital
- Go to the doctor
- Care for yourself at home

You can get help with problems like:

- Back pain
- Burns
- Colds/flu
- Coughing
- A crying baby
- Cuts
- Dizziness
- Feeling sick

A nurse is there to help. If you think it is an emergency, go to the hospital or call **911** first.

Care Management

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Get Checkups Regularly

It is important to get checkups from your doctor on a regular basis. This is true even if you feel healthy. There are many reasons to get preventive checkups. The information you will learn will help you take charge of your health!

Checkups will help you:

- Get immunizations (shots) that can help keep you from getting sick
- Check if your child is growing and developing at the right pace
- Catch early warning signs before a disease or illness gets worse
- Check “vital statistics” so your doctor can compare them when you do get sick
- Get advice on eating better, quitting smoking, or other healthy living tips

Checkups for Children

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a program for children and adolescents under 21. The EPSDT program checks children for medical problems early and as they grow. These checkups help to make sure your child is growing up healthy. If the doctor finds a problem, it is treated and watched. These benefits are available to your child with Harmony Health Plan. Children should get checkups regularly on or before the ages listed below:

- Newborn up to 5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- Every year, age 4–20

Well-visits or EPSDT checkups include:

- Medical history and physical exam
- Growth and development checks (social, personal, behavioral, language and motor skills)
- Hearing screens
- Oral health and dental screenings
- Lab tests, including blood screenings and lead level testing
- Mental health and substance abuse
- Nutrition
- Immunizations (shots)
- Health education for parents, including information on prevention, safety and risk behaviors
- Referrals for diagnosis and/or treatment when needed
- Vision screens

It is important for children to have all of the EPSDT visits.

These guidelines are recommendations only. Other services may be needed.

Age	Screening/Immunizations (Shots) and Timing
Newborn	<ul style="list-style-type: none"> • Well-baby* checkup at birth • Vision and Hearing screening • Heart defect screening • Newborn screening blood tests • Immunizations: Dose 1 of 2 of the Hepatitis B (HepB) vaccine
3–5 days	<ul style="list-style-type: none"> • This visit is especially important if your baby was sent home within 48 hours of birth. • Well-baby* checkup as recommended by doctor • Newborn screening blood tests (if not done at birth) • Heart defect screening (if not done at birth) • Immunizations: Dose 2 of 2 of the Hepatitis B (HepB) vaccine, if not already received • TB screening • Vision and Hearing screening (if not done at birth)

Age	Screening/Immunizations (Shots) and Timing
1 month	<ul style="list-style-type: none"> • Well-baby* checkup • Newborn screening blood tests if not already completed • Immunizations: Dose 2 of 2 of the Hepatitis B (HepB) vaccine, if not already received • TB screening (if not done previously) • Vision and Hearing screening (if not done at birth)
2 months	<ul style="list-style-type: none"> • Well-baby* checkup • Newborn screening blood tests if not already completed • Immunizations: Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenzae type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines
4 months	<ul style="list-style-type: none"> • Well-baby* checkup • Newborn screening blood tests if not already completed • Immunizations: Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Haemophilus influenzae type b (Hib); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccine
6 months	<ul style="list-style-type: none"> • Well-baby* checkup • Newborn screening blood tests if not already completed • Immunizations <ul style="list-style-type: none"> - Dose 3 of the Hepatitis B (HepB) vaccine (recommended between ages 6 to 18 months) - Rotavirus (RV); Diphtheria, Tetanus, and Pertussis (DTaP); Pneumococcal conjugate (PCV); and inactivated poliovirus (IPV) vaccines - Begin yearly flu shot (fall or winter). • TB screening, oral health screening and blood lead risk assessment

Age	Screening/Immunizations (Shots) and Timing
9 months	<ul style="list-style-type: none"> • Well-baby* checkup • Newborn screening blood tests if not already completed, including hemoglobin or hematocrit • Immunizations <ul style="list-style-type: none"> - Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) - Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) - Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health, and oral health as well as a blood lead risk assessment
12 months (1 year)	<ul style="list-style-type: none"> • Well-baby* checkup • Catch-up immunizations as needed • Newborn screening blood tests if not already completed, including hemoglobin or hematocrit if not done at 9-month visit • Immunizations <ul style="list-style-type: none"> - Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) - Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) - Haemophilus influenzae type b (Hib); Pneumococcal conjugate (PCV); Varicella (VAR); Measles, Mumps, Rubella (MMR); and the Hepatitis A (HepA) vaccines - Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health and oral health as well as a blood lead risk assessment • Dental visit as need identified by child's doctor**

Age	Screening/Immunizations (Shots) and Timing
15 months	<ul style="list-style-type: none"> • Well-baby* checkup • Catch-up immunizations as needed • Immunizations <ul style="list-style-type: none"> - Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months) - Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (recommended between ages 15 to 18 months) - Haemophilus influenzae type b (Hib) and Pneumococcal conjugate (PCV) vaccines - Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) - Dose 2 of Hepatitis A (HepA) vaccines (recommended between ages 12–23 months) - Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health, and oral health as well as a blood lead risk assessment • Dental visit as need identified by child’s doctor**

Age	Screening/Immunizations (Shots) and Timing
18 months	<ul style="list-style-type: none"> • Well-baby* checkup • Catch-up immunizations as needed • Immunizations <ul style="list-style-type: none"> - Dose 3 of the Hepatitis B (HepB) vaccine (if not already received; recommended between ages 6 to 18 months. - Dose 4 of the Diphtheria, Tetanus, and Pertussis (DTaP) vaccine (if not already received; recommended between ages 15 to 18 months) - Dose 3 of the inactivated poliovirus (IPV) vaccines (if not already received; recommended between ages 6 to 18 months) - Dose 2 of Hepatitis A (HepA) vaccines (to be taken 6 months after dose 1; recommended between ages 12–23 months) - Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health, autism and oral health as well as a blood lead risk assessment • Dental visit as need identified by child’s doctor**
24 months (2 years)	<ul style="list-style-type: none"> • Well-baby* checkup • Catch-up immunizations as needed • Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health, autism, oral health and cholesterol (dyslipidemia) as well as a blood lead risk assessment • Dental visit as need identified by child’s doctor**

Age	Screening/Immunizations (Shots) and Timing
3 years	<ul style="list-style-type: none"> • Well-child* checkup • Catch-up immunizations as needed • Yearly flu shot if not already received • Screenings for TB, developmental health, behavioral health, autism, oral health, vision, and cholesterol (dyslipidemia) • Blood lead risk assessment (if not completed between ages 12 and 24 months) • Dental visit as need identified by child’s doctor**; may be up to twice a year
4–5 years	<ul style="list-style-type: none"> • Well-child* checkup • Catch-up immunizations as needed • Dose 5 of the DTaP vaccine • Dose 4 of the IPV vaccine • Dose 2 of the MMR vaccine • Dose 2 of the VAR vaccine • Yearly flu shot, if not already received • Screenings for TB, developmental health, behavioral health, autism, oral health, hearing, vision (between ages 4 and 5 years) and cholesterol (dyslipidemia) (if not done at age 3) • Blood lead risk assessment (if not completed between ages 12 and 24 months) • Dental visit as need identified by child’s doctor**; may be up to twice a year • Urine test at age 5

Age	Screening/Immunizations (Shots) and Timing
6–20 years (even years)	<ul style="list-style-type: none"> • Well-child* checkup every year • Catch-up immunizations as needed • Human papillomavirus vaccine (HPV) at a minimum age of 9 • Yearly flu shot if not already received. • Dental visit twice a year • Screenings for TB, developmental and behavioral health • Hearing tests at ages 6, 8 and 10 • Vision screening at ages 6, 8, 10, and 12; follow-up screenings should be done at age 15 and 18 • Cholesterol (dyslipidemia) screening at ages 6, 8 and 10 then every year • Blood sugar screening beginning at age 10 and continuing every 3 years when at risk (see below) • Blood lead risk assessment (at age 6)
11–17 Years	<ul style="list-style-type: none"> • Well-child* checkup every other year. • Catch-up immunizations as needed • Human papillomavirus vaccine (HPV) at a minimum age of 9 • Dose 1 of Meningococcal conjugate vaccine (MCV) • MCV4 booster (at age 16 years). Tdap if not done previously • Tetanus, diphtheria and pertussis (Tdap) • Yearly flu shot if not already received • Dental visit twice a year

Age	Screening/Immunizations (Shots) and Timing
18–20 Years (up to 21 st birthday)	<ul style="list-style-type: none"> • Well-child* checkup every other year • Catch-up immunizations as needed • Yearly flu shot if not already received • Dental visit twice a year • STI screening for sexually active individuals, as needed • Human papillomavirus vaccine (HPV) at a minimum age of 9

*** Well-baby, -child and -adolescent checkups may include:**

- Physical exam (with infant totally unclothed or older child undressed and suitably covered)
- Health history, developmental and psychosocial/behavioral assessment, health education (sleep position counseling from 0–9 months, injury/violence prevention and nutrition counseling)
- Height, weight, test for obesity (known as BMI)
- Vision and hearing screening
- Head circumference at 0–24 months
- Blood pressure at least every year beginning at age 3

**Dental visits may be recommended beginning at age 6 months.

***Females should have a Pap smear starting at age 21, With the exception of women who are infected with HIV or who are otherwise immunocompromised.

Immunizations

Immunizations are shots that help the body fight disease. Children will get shots during some of the well-child checkups. Children must have all the shots they need before they can start school. Check with your child's provider to be sure that your child has all the needed shots. Here is the recommended childhood and adolescent immunization schedule:

Recommended Immunizations For Babies	
Age	Recommended Immunization(s)
At birth	Hepatitis B (HepB)
2 months	Diphtheria, Tetanus and Pertussis (DTaP), HepB, Polio (IPV), Pneumococcal (PCV), Haemophilus influenzae type b (Hib) shots, Rotavirus (RV)
4 months	DTaP, Hib, PCV, Polio, RV
6 months	DTaP, HepB, Hib, IPV, PCV, RV, Influenza (flu)
12 months	Measles, Mumps, Rubella (MMR), Hib, 2 Hepatitis A (HepA) shots, Varicella (chicken pox), PCV, flu
15 months	DTaP, flu
18 months	Flu
24 months	Flu

Vaccine Descriptions

- HepB: protects against hepatitis
- DTaP: a combined vaccine that protects against diphtheria, tetanus and pertussis (whooping cough)
- PCV: protects against pneumococcal disease

- Hib: protects against Haemophilus influenzae Type b
- Polio: protects against polio; the vaccine is also known as IPV
- RV: protects against infections caused by the Rotavirus
- MMR: protects against measles, mumps and rubella (German measles)
- Varicella: protects against varicella, also known as chicken pox
- HepA: protects against hepatitis A
- Influenza: protects against influenza (flu)
- HPV: protects against cervical cancer
- MCV4: protects against meningococcal conjugate vaccine

This may seem like a lot of shots. But they are needed to prevent disease. The visits also help the doctor make sure your child is growing and learning on schedule. If you are not sure if your child needs a shot, please talk to your child's doctor right away. Your provider can also tell you what to do if your child misses a shot.

For children with asthma:

If your child has not seen their doctor in the past 3 months, call and make an appointment. Your child's PCP can work with you to help keep your child's asthma under control and on track with their asthma action plan.

For children with diabetes:

Testing for diabetes mellitus (DM) should start at age 10 (or at onset of puberty) and continue every three years if these criteria are met:

- Overweight (BMI >85th percentile for age and sex; weight for height >85th percentile; or weight >120% of ideal for height) AND two of the following risk factors:
 - Family history of type 2 diabetes in first- or second-degree relative
 - Race/ethnicity (Native American, African American, Latino, Asian American, Pacific Islander)
 - Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, or small for gestational age birthweight)
 - Maternal history of diabetes or GDM during the child's gestation

If your child has diabetes and has not seen their doctor in the past 3 months, make an appointment. This will help your child stay healthy and avoid other health problems from diabetes. National guidelines recommend all diabetics be seen every 3 months, and have these tests:

- Blood sugar average should be done at least twice a year. A member's hemoglobin A1c (HbA1c) should be less than 7 percent.
- LDL cholesterol should be done at least yearly. Treatment may be necessary if LDL results are greater than 100mg/dL.
- Dilated Eye Exam should be done yearly by an eye doctor to check for diabetic retinopathy.
- Foot exam should be done yearly.
- Urine test for protein and microalbumin should be done yearly to check how well the kidneys are working.

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Adult Preventive Care Guide

The following chart lets you know what care or screening you may need for someone your age and gender. For example, if you are a 25-year-old female, please find that row for the preventive care you may need. Your PCP will also know what preventive services you need.

If you're new to our health plan, you should get a baseline physical exam within the first 90 days of joining our plan. If you're pregnant, you should get this done within 14 days.

Recommendations for periodic health exam visits for asymptomatic adults are:

- Ages: 18 to 39 years: Exam frequency: every 1 to 3 years (annual Pap smears are indicated for females who have 3 consecutive normal smears; for females with normal smears, the recommendation is a Pap smear every 3 years) (Note: In some markets, 21 to 39 years)
- Ages 40 to 64 years: Exam Frequency: every 1 to 2 years based on risk factors
- Ages 65 and Over: Exam frequency: every year

Age	Screening	Frequency
Adolescents 18 years and older Adults 21 years and older	Blood Pressure, Height, Body Mass Index (BMI), Alcohol Use	Annually, 18-21 years. After 21, every 1-2 years or per PCP recommendations
Adults 21 years and older, especially if at high risk	Cholesterol	Every 5 years (More frequent if elevated)

MEMBER SERVICES

Age	Screening	Frequency
Females 21 years and older	Pap Smear	Every 3 Years for women ages 21–29). Every 3–5 years for women ages 30–65 years.
Females 40 years and older	Mammography	Every 1–2 years
Females under 25 years and sexually active women 25 years and older if at increased risk	Screening for sexually transmitted infections	Every year
50 years and older	Colorectal	Periodically depending upon test
50 years and older	Hearing Screening	Periodically
Females >65 years old, or >60 years at risk	Osteoporosis (Bone Mass Measurement)	Every 2 years or per PCP's recommendations
65 years and older, or younger for those that have diabetes or other risk factors	Vision including glaucoma or diabetic retinal exam as needed	Every two years for routine exams or annual if diabetic or other risk factors

Immunizations	
Tetanus-Diphtheria and acellular pertussis (Td/Tdap)	18 years and older, Tdap: Substitute 1-time dose of Tdap for Td then boost with Td every 10 years
Varicella (VZV)	All adults without evidence of immunity to varicella should receive 2 doses of single-antigen varicella vaccine if not previously vaccinated or the second dose if they have received only 1 dose.
Measles, Mumps, Rubella (MMR)	Adults born during or after 1957 should receive 1–2 doses
Pneumococcal polysaccharide (PPSV)	65 years and older, all adults who smoke or have certain chronic medical conditions – 1 dose. May need a 2 nd dose if identified at risk.
Seasonal Influenza	All adults every year
Hepatitis A Vaccine (HepA)	All unvaccinated individuals who anticipate close contact with an international adoptee or those with certain high-risk behaviors.
Hepatitis B vaccine (HepB)	Adults at risk, 18 years of age and older – 3 doses

Immunizations	
Meningococcal conjugate vaccine (MCV)	College freshmen living in dormitories not previously vaccinated with MCV and others at risk, 18 years of age and older – 1 dose. Meningococcal polysaccharide vaccine) is preferred for adults ages 56 years and older
Human Papillomavirus (HPV)	*For eligible members through 26 years of age (three dose series)
Zoster	Age 60 and older – 1 dose
Haemophilus Influenza type b (Hib)	*For eligible members who are at high-risk and who have not previously received Hib vaccine (1 dose)

Annual Women’s Health Exam

Getting your women’s health exam every year is an important part of staying healthy.

During this exam, your provider will:

- Review your medical and gynecological history
- Take your blood pressure, weight and other vital signs
- Examine your body. This includes your skin and other parts of your body, to check your overall health
- Do a clinical breast exam
- Check to see if your cervix, ovaries, uterus, vagina and vulva are of normal size, shape and position
- Check for signs of sexually transmitted infections (STIs), cancer and other health problems

- Perform a Pap test if needed
- Talk with you about birth control and protection from STIs

If you haven't had your yearly women's health exam, set one up today. We can help you find a provider. We can also help you set up a visit. Give us a call.

Prevention

- Discuss aspirin to prevent cardiovascular events
 - Men – 40 years and older, periodically
 - Women – 50 years and older, periodically
- Discuss the importance of preventive exams (mammograms and breast self-examination for women at high risk and who have family history)
- Discuss prostate-specific antigen (PSA) test and rectal exam for men 40 years and older, per PCP discretion

Counseling

- **Calcium Intake:** 1,000mg/day (women age 18–50 years old), 1200–1500 mg/day (women >50 years)
- **Folic Acid:** 0.4 mg/day (women of childbearing age); women who have had children with Neural Tube Defects (NTD) should take 4 mg/day
- **Miscellaneous Topics:** tobacco cessation, drug/alcohol use, STDs/HIV, nutrition, breast-feeding (for pregnant women), physical activity, sun exposure, oral health, injury prevention, medication lists and poly-pharmacy, and advanced directives

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Legal Disclaimer: Preventive health guidelines are based on guidelines from third parties available before printing; these guidelines are not a replacement for your doctor's medical advice; he/she may have more current details; you should always talk with your doctor(s) about what care and treatment is right for you; the fact that a service or item is in these guidelines is not a guarantee of coverage or payment; members should look at their own plan coverage papers to see what is or is not a covered benefit; The Health Plan does not offer medical advice or provide medical care, and does not guarantee any results or outcomes. In addition, the Health Plan does not warrant or guarantee, and shall not be liable for:

- Information in these guidelines
- Information not in these guidelines
- Any recommendations made by independent third parties from whom any of the information was obtained

Care Before You Get Pregnant

Being a parent is a full-time job. Before you get pregnant, think about the emotional and lifestyle issues you will face as a parent. It's important for you and your partner to talk about big issues. You should agree on them or begin talking about your differences. These talks should happen before you get pregnant. Only you can decide if you're ready for a baby.

Also, the physical health of the mom and dad before pregnancy can affect the health of your future baby. There are certain things you can do to help your baby even before you're pregnant.

If You Are	You Need
Male age 21–34	Annual physical exam, Tetanus-Diphtheria booster
Female age 21–34	Annual physical exam, Pap smear, chlamydia screening (ages 18–25), HPV vaccine (if you are under 26), Tetanus-Diphtheria booster
Male age 35–49	Annual physical exam, cholesterol testing, Tetanus-Diphtheria booster
Female age 35–49	Annual physical exam, Pap smear, cholesterol testing (if you are over 44), Tetanus-Diphtheria booster
Male age 50–64	Annual physical exam, cholesterol testing, Tetanus-Diphtheria booster, colonoscopy, flu shot
Female age 50–64	Annual physical exam, Pap smear, cholesterol testing, mammogram, Tetanus-Diphtheria booster, colonoscopy, flu shot

What you can do:

- Take a multivitamin with folic acid every day before you get pregnant
- Get a pre-pregnancy checkup, including a dental checkup
- Eat healthy food, maintain a healthy weight and get fit
- Stop smoking and avoid secondhand smoke
- Stop drinking alcohol
- Don't use illegal drugs
- Avoid infections because some can harm a fetus
- Avoid hazardous substances and chemicals
- Talk to your health care provider about your family history
- Avoid stress

Prenatal Visits

When you are pregnant, you need to visit your provider. The number of visits changes during pregnancy. From months 1 to 6: one visit a month. From months 7 to 8: two visits a month. In month 9: one visit a week. Remember that the use of alcohol, tobacco and illicit drugs may lead to low birth weight babies and birth defects.

Prenatal Program

Harmony Hugs Program

Harmony Hugs is our special program for pregnant women. It is Harmony's goal to ensure our mothers-to-be get the care they need before and after they have a baby. We want you to seek care very early in your pregnancy. This allows us to arrange for tests that look for any risks you may face. We will also assign someone who will help you through your pregnancy.

You decide if you want to join Harmony Hugs. We will assign a care manager to you. The care manager calls you based on your risk level and your needs. When the care manager calls, they will ask about your pregnancy and give you information. We will also send you educational materials during your pregnancy. We will encourage you to schedule exams for yourself and your baby. Newborn babies need a series of regular checkups.

You may also be eligible for our Prenatal Rewards program. If so, you may get a free new baby stroller or a portable play yard. To earn the reward, you must go to at least 6 prenatal visits.

To qualify for the reward, you must be enrolled with Harmony:

- When you had the 6 prenatal visits,
- When you deliver your baby, and
- At the time the items you select are sent to you.

To join the Harmony Hugs Program and learn more about our Prenatal Rewards Program, please call Harmony Hugs at **1-866-776-9876** (TTY **1-877-650-0952**) as soon as you find out you are pregnant.

You Should Know: Stay close to your provider and the hospital where you will have your baby during your ninth month of pregnancy. Check with your provider to make sure it is safe to leave if you need to go out of town. Your medical bills may not be covered if your provider tells you to stay in town but you have your baby out of town.

Before Another Pregnancy (Intraconceptual Care)

You may not be thinking about having another baby right now, but that might change in the future. So it's important to stay healthy.

What you can do:

- Leave time between pregnancies. For most women, it's best to wait at least 18 months before getting pregnant again. This gives your body enough time to get ready for another pregnancy. Babies are born healthier when there is plenty of time between pregnancies.
- Use birth control until you're ready to get pregnant again. Your provider will help you choose the best one for you.
- Take a multivitamin every day before you get pregnant. Make sure it has folic acid.
- Get a checkup before getting pregnant again.

Harmony Healthy Kids Club

The Harmony Healthy Kids Club is for children 4–11 years old. Kids get tips and ideas for living healthy. As fun incentives, they receive a personalized membership card and complimentary tee shirt. During their birth month, they get a special card from the club.

Recipient Restriction Program:

Our Pharmacy Lock-in Program helps to coordinate your drug and medical care needs. You may see a number of different doctors for your care. And each doctor may prescribe a different drug for you, which can sometimes be dangerous. So to help with this, we have a Pharmacy Lock-In program.

The program helps to coordinate your drug and medical care needs. If you are in this program, you will get all of your prescriptions for controlled substances from one pharmacy. This will help the pharmacist to understand your prescription needs. You may still get other medications from other prescribers and pharmacies.

If we feel you would benefit from this program, we may “lock” you into one pharmacy. We’ll send you a letter to let you know if you are in this program. We’ll also let your PCP and pharmacy know.

For questions about our lock-in program, give us a call at **1-800-608-8158** (TTY **1-877-650-0952**)

Advance Directives:

An advance directive is a written decision you make about your health care in the future in case you are so sick you can’t make a decision at that time. In Illinois there are four types of advance directives:

- **Healthcare Power of Attorney** – This lets you pick someone to make your health care decisions if you are too sick to decide for yourself.
- **Living Will** – This tells your doctor and other providers what type of care you want if you are terminally ill which means you will not get better.
- **Mental Health Preference** – This lets you decide if you want to receive some types of mental health treatments that might be able to help you.
- **Do Not Resuscitate (DNR) Order** – This tells your family and all your doctors and other providers what you want to do in case your heart or breathing stops.

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

The law says your doctor or hospital has to ask if you have made an “advance directive.” This is a paper that tells the doctor and hospital what type of care you want to get or not get if you are so sick you will not get better. This care may include things like feeding tubes or restarting your heart if it stops beating. Advance directives can also state your wishes to donate specific organs or your entire body. This is sometimes called a “living will.”

You also can name a person to make those decisions for you if you are not able to. This is called “durable power of attorney” for health care decisions.

You should give a copy of your advance directive to your PCP. Your local hospital can give you a copy of the advance directive form.

Grievance & Appeals:

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

Grievances

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

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

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

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

MEMBER SERVICES

You can file your grievance on the phone by calling Harmony at **1-800-608-8158** (TTY **1-877-650-0952**). You can also file your grievance in writing via mail or fax at:



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

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling Member Services at **1-800-608-8158** (TTY **1-877-650-0952**).

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

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

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

Appeals

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

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

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

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

Here are two ways to file an appeal.

1. Call Member Services at **1-800-608-8158** (TTY **1-877-650-0952**). If you file an appeal over the phone, you must follow it with a written signed appeal request.
2. Mail or fax your written appeal request to:

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

Harmony Health Plan
Attn: Pharmacy Medication
Appeals Department
P.O Box 31398
Tampa, FL 33631-3398
Fax: 1-888-865-6531

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

Can someone help you with the appeal process?

You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your Primary Care Physician or a family member, for example.

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

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

Appeal Process

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

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

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

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

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

Things to keep in mind during the appeal process:

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

How can you expedite your Appeal?

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

How can you withdraw an Appeal?

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

Harmony will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Harmony at **1-800-608-8158** (TTY **1-877-650-0952**)

What happens next?

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

State Fair Hearing

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

At the State Fair Hearing, just like during the Harmony Appeals process, you may ask

someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

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

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



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

Fax: (312) 793-2005

Email: HFS.FairHearings@illinois.gov

Or you may call 1-855-418-4421 (TTY) 1-800-526-5812

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



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



Fax: (312) 793-8573

Email: DHS.HSPApeals@illinois.gov



Or you may call 1-800-435-0774 (TTY) 1-877-734-7429

State Fair Hearing Process

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

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

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

Continuance or Postponement

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

Failure to Appear at the Hearing

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

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

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

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

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

The State Fair Hearing Decision

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

External Review (for medical services only)

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

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

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

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



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

What Happens Next?

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

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

Expedited External Review

If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an expedited external review. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at **1-800-608-8158** (TTY **1-877-650-0952**). To ask in writing, send us a letter at the address below. You can only ask one (1) time for an external review about a specific action. Your letter must ask for an external review of that action.



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

What happens next?

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

Rights & Responsibilities:

Your rights:

- Be treated with respect and dignity at all times.
- Have your personal health information and medical records kept private except where allowed by law.
- Be protected from discrimination.

- Receive information from Harmony in other languages or formats such as with an interpreter or Braille.
- Receive information on available treatment options and alternatives
- Receive information necessary to be involved in making decisions about your healthcare treatment and choices.
- Refuse treatment and be told what may happen to your health if you do.
- Receive a copy of your medical records and in some cases request that they be amended or corrected.
- Choose your own primary care provider (PCP) from the Harmony. You can change your PCP at any time.
- File a complaint (sometimes called a grievance), or appeal without fear of mistreatment or backlash of any kind.
- Request and receive in a reasonable amount of time, information about your Health Plan, its providers and policies.
- Exercise your rights, with the assurance that the exercise of those rights will not adversely affect the way you are treated
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;

Your responsibilities:

- Treat your doctor and the office staff with courtesy and respect.
- Carry your Harmony ID card with you when you go to your doctor appointments and to the pharmacy to pick up your prescriptions.
- Keep your appointments and be on time for them.
- If you cannot keep your appointments cancel them in advance.
- Follow the instructions and treatment plan you get from your doctor.
- Tell your health plan and your caseworker if your address or phone number changes.
- Read your member handbook so you know what services are covered and if there are any special rules.

Fraud, Abuse and Neglect:

To report Fraud, Abuse and Neglect, call our 24-hour hotline at **1-866-678-8355**.

Fraud, Abuse and Neglect are all incidents that need to be reported.

Fraud occurs when someone receives benefits or payments they are not entitled to. Some other examples of fraud are:

- To use someone else's ID card or let them use yours.
- A provider billing for services that you did not receive.

Abuse is when someone causes physical or mental harm or injury. Here are some examples of abuse:

- Physical abuse is when you are harmed such as slapped, punched, pushed or threatened with a weapon.
- Mental abuse is when someone uses threatening words at you, tries to control your social activity, or keep you isolated.
- Financial abuse is when someone uses your money, personal checks or credit cards without your permission.
- Sexual abuse is when someone is touching you inappropriately and without your permission.

Neglect occurs when someone decides to hold the basic necessities of life such as food, clothing, shelter or medical care.

If you believe you are a victim you should report this right away. You can call member services at **1-800-608-8158** (TTY **1-877-650-0952**).

If you suspect abuse, neglect or exploitation you should immediately report it to the following agencies.

- To report abuse/neglect/exploitation of persons with a mental illness, a developmental or physical disability including residents of Department of Human Services (DHS)-operated facilities, call the Office of the Inspector General (OIG) 24-hour Hotline **1-800-368-1463** (Voice/TTY)
- To report abuse/neglect/exploitation of dependent adults ages 18–59 and persons 60 and older not living in a nursing home, call the Illinois Department on Aging (IDoA) Adult Protective Services Hotline at **1-866-800-1409** (Voice), (TTY **1-888-206-1327**)

- To report abuse/neglect for those in Hospitals or Nursing Homes call the IDPH Hotline **1-800-252-4343**
- Reports about people in Supportive Living Facilities (SLF) must be made to the Department of Healthcare and Family Services' SLF Complaint Hotline at **1-844-528-8444**.
- To report abuse or neglect of children 18 years and younger call the Child Abuse Hotline **1-800-25-ABUSE (1-800-252-2873)**.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

Discrimination is Against the Law

Harmony Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Harmony Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Harmony Health Plan:

- 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, Braille, 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 Harmony Member Services at **1-800-608-8158** (TTY: **1-877-650-0952**), Monday – Friday from 8 a.m. to 5 p.m., for help or you can ask Member Services to put you in touch with a Civil Rights Coordinator who works for Harmony Health Plan.

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

Harmony Health Plan, Grievance Department, P.O. Box 31384, Tampa, FL 33631-3384; Telephone **1-866-530-9491**; TTY number **1-877-247-6272**; Fax: **1-866-388-1769**; **OperationalGrievance@wellcare.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Harmony Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/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, DC 20201, **1-800-368-1019**, **800-537-7697** (TDD).

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-608-8158** (TTY: **1-877-650-0952**).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-608-8158** (TTY: **1-877-650-0952**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-608-8158** (TTY: **1-877-650-0952**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-608-8158** (TTY: **1-877-650-0952**)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-608-8158** (TTY: **1-877-650-0952**) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-608-8158** (TTY: **1-877-650-0952**).

لصتا. ن اجملاب كل رفاوتت ةيوغلل ا ةدعاسملا تامدخ نإف، ةغلل ركذا ثدحتت تنك اذا: ةظوحلم
مكبل او مصلا فتاه مقر) **1-800-608-8158** (TTY: **1-877-650-0952**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-608-8158** (TTY: **1-877-650-0952**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-800-608-8158 (TTY: **1-877-650-0952**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں
1-800-608-8158 (TTY: **1-877-650-0952**).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-608-8158** (TTY: **1-877-650-0952**).

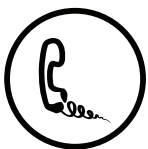
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-608-8158** (TTY: **1-877-650-0952**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-608-8158 (TTY: **1-877-650-0952**) पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-608-8158** (TTY: **1-877-650-0952**).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-800-608-8158** (TTY: **1-877-650-0952**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-608-8158** (TTY: **1-877-650-0952**).



1-800-608-8158
(TTY 1-877-650-0952)



www.harmonyhpi.com

