

Family Health Network Certificate of Coverage

Providing Healthcare to Illinois Participants
in All Kids, FamilyCare, Moms & Babies



FAMILY HEALTH
NETWORK

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Certificate of Coverage



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Certificate of Coverage – Family Health Network

This Certificate of Coverage (Certificate) is issued by Family Health Network (FHN), pursuant to a Contract for Furnishing Health Services (the Contract) between FHN and Healthcare and Family Services (HFS) formerly known as Illinois Department of Public Aid (IDPA) to provide Eligible Enrollees and their eligible dependents with the services and benefits described in this Certificate. This Certificate of Coverage replaces and supersedes any previous issued certificates. It is governed by the current contract.

Section I: Definitions of Terms

Case – Individuals who have been grouped together and assigned a common identification number by the Department of Human Services and at least one individual in that grouping has been determined by the Department to be an Eligible Enrollee.

Certificate of Coverage – This document, which explains the covered services and benefits of the Family Health Network.

Contract – The contract, addenda, and amendments signed by Family Health Network (the Plan) which constitute the agreement regarding the benefits, exclusions and other conditions between the Plan and HFS.

Contracting Area – Cook County, Illinois.

Covered Services – Those benefits, supplies and services covered under the Plan, listed in this Certificate of Coverage.

Disenrollment – The voluntary or involuntary termination of all benefits and services covered by Family Health Network.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in:

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Services – With respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. “Emergency services” does not refer to post-stabilization medical services.

Enrollee or Member – Any person who is enrolled in Family Health Network.

Excluded Services – Services and supplies not covered by Family Health Network.

EPSDT – The Early and Periodic, Screening, Diagnostic and Treatment services provided to children under Title XIX of the Social Security Act (42 U.S.C. § 1396, *et seq.*).

FHN - Family Health Network, which is the not-for-profit managed care community network of physicians and hospitals providing Medical services to Enrollees in the Family Health Network.

HFS – Healthcare and Family Services, formerly known as the Department of Public Aid

Medically Necessary – The use of services or supplies as provided by a health care provider to identify or treat an Enrollee’s condition, illness, disease or injury and which are determined to be (a) appropriate for the symptoms, diagnosis or treatment; (b) according to standards of good medical practice; (c) not primarily for the convenience of the Enrollee or provider; and (d) the most appropriate supply or level of service that can safely be provided to the Enrollee.

Member or Enrollee – Any person who is enrolled in Family Health Network

Out-of-Area Services – Those services provided outside FHN’s service area. Covered out-of-area services are limited to emergency conditions and services that are arranged by the Enrollee’s PCP and/or an FHN Medical Manager.

Out-of-Network Services – Those services provided outside of the FHN network of providers by non-participating providers. In these circumstances, covered services are limited to emergency conditions and services that are arranged for by the Enrollee’s PCP and/or an FHN Medical Manager.

Participating Hospital – A hospital that has entered into a service agreement with Family Health Network for the care of Enrollees.

Participating Physician – Any physician who has entered into a service agreement with FHN to provide health services to Enrollees of the Family Health Network or on whose behalf a contract has been entered into with FHN, to participate as a provider of health services under FHN programs.

Plan – Family Health Network.

Physician – A person licensed under the Medical Practice Act of 1987 and who is currently enrolled as a provider in the Illinois Medical Assistance Program.

Post-stabilization Medical Services – Health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and are determined to be medically necessary and directly related to the emergency medical condition following stabilization.

Preventive Services – covered services to assist with the early detection and/or prevention of illness and impairment.

PCP – An FHN Participating Primary Care Physician who is selected by the Enrollee to be responsible for providing or authorizing health care services covered by the Plan. This includes Pediatrics, Family Practice, OB/Gynecology, Internal Medicine and/or General Practice.

Provider – A person or facility who is approved by HFS to furnish medical services to Medicaid participants enrolled in Family Health Network.

Service Area – The geographic area where a person must live to qualify for enrollment or remain an Enrollee in the Plan. The FHN Service area is Cook County, Illinois.

Urgent Care – Health care needed for a condition that does not require Emergency Care but for which, based on medical appropriateness, treatment must be provided within 24 hours and should not wait for a normally scheduled appointment.

Women’s Health Care Provider (WHCP) – A physician specializing by certification in obstetrics, gynecology, or family practice.

Section II: Eligibility and Enrollment

A. Eligibility

1. Enrollment in this Plan is open to Eligible Enrollees meeting the eligibility requirements set forth by HFS.
2. Newborn children of an Enrollee are Eligible Enrollees if they are so designated by HFS. The mother has a right not to enroll her newborn baby in the Plan. To do so she must call the Illinois Client Enrollment Broker (ICEB) 1-877-912-8880.

B. Enrollment

1. Enrollment in this Plan is voluntary.
2. FHN and HFS and, or it’s contracted client enrollment broker are responsible for the Enrollment of Eligible Enrollees.
3. Eligible Enrollees who wish to enroll must complete the process using the procedure in place by HFS.
4. At the time of Enrollment, Eligible Enrollees shall be given information on the operation and use of the Plan and of their right to voluntarily disenroll at any time.
5. When an enrollee, who is a head of a case, gives birth and the newborn is added to the case

before the newborn is 45 days old, the newborn shall be automatically enrolled with FHN.

Coverage shall be retroactive to the date of birth.

Potential enrollees age 46 days through 1 year are added to a case in which the mother is the head of the case and an enrollee will be enrolled with FHN automatically. Coverage will be prospective.

Potential enrollees through age 18 who are added to a case in which all members of the case are enrolled with the contractor will be enrolled with a contractor automatically. Coverage shall be prospective.

6. FHN shall provide new enrollees a new member packet that includes business address and telephone number, service hours, regular and emergency telephone numbers, enrollment and disenrollment procedures, covered services, grievance procedures, identification card(s) showing the effective date of coverage and the 24 hour telephone number to confirm eligibility for benefits and authorization for services and the name and phone number of the doctor. You may request an additional copy of this information at any time.

Section III: Effective Date and Disenrollment

A. Effective Date and Term of Coverage.

1. Coverage begins on a date determined by HFS. The FHN Identification Card and your HFS Medical card will indicate the effective date of enrollment. This is when you will begin receiving your care from Family Health Network.
2. FHN assumes financial responsibility for treatment of medical conditions and/or existing treatment plans of each Enrollee as of the effective date of coverage as defined in the contract. You must call Member Services to request “Transition of Care” to allow the staff to arrange for the needed transition to a FHN physician.
3. Every enrollee remains enrolled until coverage is ended, pursuant to Section IIIB.

B. Disenrollment (Termination of Coverage)

1. An Enrollee shall be disenrolled and coverage shall be terminated subject to HFS actions as follows:
 - a. At such time when HFS determines that the Enrollee is no longer eligible to be enrolled in a managed care plan.
 - b. At such time when an Enrollee elects to terminate coverage by so informing FHN or ICEB. Enrollees may elect to disenroll at any time.
 - c. At such time when an Enrollee no longer resides in FHN’s Service Area;
 - d. Dismissal from the Plan by FHN for “Good Cause” shown with the written approval of such termination by the Administrator of HFS’s Medical Assistance Program. For

- purposes of this paragraph, “Good Cause” may include, but is not limited to, fraud or other misrepresentation by an Enrollee, threats or physical acts constituting battery to FHN personnel, theft of property from FHN sites, chronic abuse of Hospital Emergency Room services, continuing and persistent refusal to accept treatment and/or procedures recommended by the Participating Physician, or other acts of an Enrollee presented to HFS by FHN which the Administrator of the Medical Assistance Program determines constitute “good cause”.
2. FHN shall not disenroll an Enrollee because of adverse change in the Enrollee’s health or cost of medical care.

3. The termination of the contract agreement between FHN and HFS will result in automatic disenrollment of all covered Enrollees.
4. No Enrollee shall be terminated from FHN on the basis of health status, race, color, national origin, ancestry, religion, age, sex, marital status, handicap, or sexual orientation.

C. Continuation of Coverage Following Disenrollment

If an Enrollee is receiving inpatient services in a Participating Hospital at the time of disenrollment Participating Physicians will continue to provide services until it is medically safe for the individual to leave the hospital.

Section IV: Covered Services

In consideration of payments made by HFS, the following services shall be provided to an Enrollee if, as determined by the Enrollee’s PCP and/or WHCP, they are:

- A. Reasonable and medically necessary for:
 - the diagnosis or treatment of an illness or injury,
 - wellness care, or
 - general health maintenance; and
- B. The services are rendered by the Enrollee’s PCP or WHCP or a Participating Provider referred by the Enrollee’s PCP or WHCP. If the PCP determines that the Enrollee needs to see another Physician (a Specialist), he or she will refer the Enrollee to such Physician.

Medically Necessary Covered Services

The following services and benefits are included as covered Services and will be provided to Beneficiaries whenever medically necessary:

- Assistive/augmentative communication devices;
- Audiology services, physical therapy, occupational therapy, and speech therapy;
- Behavioral health services, including subacute alcohol and substance abuse services and mental health services, in accordance with subsection (c) herof;
- Blood, blood components and administration thereof;
- Certified hospice services;
- Chiropractic services;
- Clinic services (as described in 89 Ill. Adm. Code, Part 140.460);
- Diagnosis and treatment of medical conditions of the eye;
- Durable and nondurable medical equipment and supplies;
- Emergency Services;
- Family Planning Services; See Section IX:C
- Home Health Care Services;
- Inpatient hospital services (including dental hospitalization in case of trauma or when related to a medical condition or acute medical detoxification);
- Inpatient psychiatric care;
- Laboratory and x-ray services;*
- Medical procedures performed by a dentist;
- Nurse midwives services;
- Nursing facilities for the first ninety (90) days;**

- Orthotic/prosthetic devices, including prosthetic devices or reconstructive surgery incident to a mastectomy;
- Outpatient hospital services (excluding outpatient behavioral health services);
- Physicians’ services, including psychiatric care;
- Podiatric services;
- Pharmaceutical products provided by an entity other than a pharmacy;
- Routine care in conjunction with certain investigational cancer treatments, as provided in Public Act 91-0406;

*The drawing of blood for lead screening shall take place within the Contractor’s Affiliated facilities or elsewhere at the Contractor’s expense. All laboratory tests for children being screened for lead must be sent for analysis to the Illinois Department of Public Health’s laboratory.

**Contractors will be responsible for covering up to a maximum of ninety (90) days nursing facility care (or equivalent care provided at home because a skilled nursing facility is not available) annually per Enrollee. Periods in excess of ninety (90) days annually will be paid by the Department according to its prevailing reimbursement system.

- EPSDT Services;
- Services to Prevent Illness and Promote Health in accordance with subsection (d) herof;
- Transplants covered under 89 Ill. Adm. Code 148.82 (using transplant providers certified by the Department, if the procedure is performed in the State); and
- Transportation to secure Covered Services.

Behavioral Health Services

The Contractor will provide the following behavioral health services, which are Covered Services:

- Inpatient psychiatric or substance abuse services that are provided in general hospital medical units;
- Inpatient psychiatric services provided in a hospital that is a psychiatric hospital or a distinct psychiatric unit, as defined in 89 Ill. Adm. Code 148.40(a)(1);
- Inpatient acute alcoholism and substance abuse treatment (detoxification);

- Hospital-based organized clinic services referred to as outpatient treatment psychiatric services for Type A and Type B Psychiatric Clinic Services, as defined in 89 III. Adm. Code 148.140(b)(1)(E); and
- Behavioral health services provided by FQHCs, RHCs, and Physicians, including psychiatrists; and
- Laboratory services provided on an outpatient basis for behavioral health, even if ordered by a behavioral health provider in connection with the provision of treatment that is excluded from Covered Services.

If an Enrollee presents himself to the Contractor for behavioral health services, or is referred through a third party, the Contractor will complete a behavioral health assessment.

- If the assessment indicates that all services needed are within the scope of Covered Services, the Contractor will arrange for the provision of all such Covered Services.
- If the assessment indicates that outpatient services are needed beyond the scope of Covered Services, the Contractor will explain to the Enrollee the services needed and the importance of obtaining them and provide the Enrollee with a list of Community Behavioral Health Providers (CBHP). The Contractor will assist the Enrollee in contacting a CBHP chosen by the Enrollee, unless the Enrollee objects.
- If a Enrollee obtains needed comprehensive services through a CBHP, the Contractor will be responsible for payment for laboratory services in connection with the comprehensive services provided by the CBHP. The Contractor shall not be liable for other Covered Services provided by the CBHP. The Contractor may require that laboratory services are provided by Providers that are Affiliated with Contractor.

Services to Prevent Illness and Promote Health.

The Contractor shall make documented efforts to provide initial health screenings and preventive care to all Enrollees. The Contractor shall provide, or arrange to provide, the following Covered Services to all Enrollees, as appropriate, to prevent illness and promote health:

- EPSDT services in accordance with 89 III Adm. code 140.485 and described in this Article V, Section 5.13(a);
- Preventive Medicine Schedule which shall address preventive health care issues for Enrollees twenty-one (21) years of age or older (Article V, Section 5.13(b));
- Maternity care for pregnant Enrollees (Article V, Section 5.13(c)); and
- Family planning services and supplies, including physical examination and counseling provided during the visit, annual physical examination for family planning purposes, pregnancy testing, voluntary sterilization, insertion or injection of contraceptive drugs or devices, and related laboratory and diagnostic testing (except to the extent an Enrollee has chosen to obtain such services and supplies from a non-Affiliated Provider, in which case the Department shall be responsible for providing payment for such services).

Section V: Emergencies and Urgent Care

What is an Emergency Medical Condition?

A medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention to result in:

- (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part

What to do in an Emergency:

In the event of an Emergency Medical Condition, Enrollees should go to the closest emergency room or to the nearest FHN Network Hospital, or call 911 for assistance. FHN will cover services provided in an Emergency Medical Condition whether Enrollee is in or out of the FHN Service Area. Enrollee must have someone telephone FHN at the number listed on the FHN Member ID Card as soon as reasonably possible.

Emergency Services are covered within or outside the FHN

Service Area provided they are furnished by a provider qualified to furnish Emergency Services, and are needed to evaluate or stabilize an Emergency Medical Condition.

Enrollees should notify FHN when an Emergency Medical Condition exists so that FHN can be involved in the management of the enrollee's health care and transfer can be arranged when their medical condition is stable. Enrollee's (or someone on their behalf) should contact FHN within 24 hours or as soon as reasonably possible at the number located on the FHN Member ID Card. Follow up care must be arranged by the FHN PCP.

What is urgent care?

Urgent Care is health care needed for a condition that does not require Emergency Care but for which, based on medical appropriateness, treatment must be provided within 24 hours and should not wait for a normally scheduled appointment.

What to do if you need urgent care.

Call your PCP and tell him of your need for care. He will recommend the most appropriate form of treatment, which will likely be an office visit that day. The PCP may instruct you to go to a specific Emergency Room for care he will arrange.

Section VI: Out-of-Area Services

If an Enrollee travels outside the service area, the following services are covered:

Emergency services as defined and described in Section V are covered 24 hours per day, seven days per week in any location in the country. Should the emergency room visit result in a hospitalization, the member must notify Family Health Network as soon as reasonably possible by calling: 1-888-346-4968.

Emergency services or hospitalizations for complications of pregnancy are covered in any location.

If enrollee travels outside the service area, the following services are not covered:

Routine care or care that could have been reasonably anticipated prior to leaving the service area.

Routine delivery outside the Contracting Area is not covered. If you leave the service area during your third trimester, talk to your doctor and call Family Health Network for information. Family Health Network may not pay for your delivery if you are outside the service area.

Section VII: Exclusions and Limited Services

Non-emergency services that are not provided or referred by the member's PCP are not covered. In some cases the Medical Group and or FHN must approve of the location or provider of such referred services. You must have a written approval from the Medical Group.

The following are examples of services excluded from coverage:

- Dental services;
- Pharmacy services provided by a pharmacy;
- Mental health clinic services as provided through a community behavioral health provider as identified in 89 III. Adm. Code 140.452 and 140.454 and further defined in 59 III. Adm. Code, Part 132 "Medicaid Community Mental Health Services Program".
- Subacute alcoholism and substance abuse treatment services as provided through a community behavioral health provider as identified in 89 III. Adm. Code 148.340(a) and further defined in 77 III. Adm. Code 2090.
- Routine examinations to determine visual acuity and the refractive state of the eye, eyeglasses, other devices to correct vision, and any associated supplies and equipment. The Contractor shall refer Enrollees needing such services to Providers participating in the HFS Medical Programs who are able to provide such services, or to a central referral entity that maintains a list of such Providers.
- Nursing facility services, or equivalent care provided at home because a skilled nursing facility is unavailable, beginning on the ninety-first (91st) day of service in a calendar year;
- Services provided in an Intermediate Care Facility

for the Mentally Retarded/Developmentally Disabled and services provided in a nursing facility to mentally retarded or developmentally disabled Participants;

- Early intervention services, including case management, provided pursuant to the Early Intervention Services System Act (325 ILCS 20 et seq.);
- Services provided through school-based clinics as such clinics are defined by the Department;
- Services provided through local education agencies that are enrolled with the Department under an approved individual education plan (IEP);
- Services funded through the Juvenile Rehabilitation Services Medicaid Matching Fund;
- Services that are experimental and/or investigational in nature;
- Services provided by a non-Affiliated Provider and not authorized by the Contractor, unless this Contract specifically requires that such services be covered;
- Services that are provided without first obtaining a required referral or prior authorization as set forth in the Enrollee handbook;
- Medical and/or surgical services provided solely for cosmetic purposes; and
- Diagnostic and/or therapeutic procedures related to infertility/sterility.

Section VIII: Limitations on Covered Services

The following services and benefits shall be limited as Covered Services:

- Termination of pregnancy shall be provided only as allowed by applicable State and federal law (42 C.F.R. Part 441, Subpart E). In any such case, the requirements of such laws must be complied with and Form HFS 2390 must be completed and filed in the Enrollee's medical record. Termination of

pregnancy shall not be provided to Enrollees eligible under the State Childrens Health Insurance Program (215 ILCS 106).

- Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F). In any such case, the requirements of such laws must be fully complied with and a DPA Form 2189 must be completed

and filed in the Enrollee's medical record.

- If a hysterectomy is provided, a DPA Form 1977 must be completed and filed in the Enrollee's medical record.

Section IX: Other Important Information

A. Women's Health Care Provider

Illinois law allows you to select a "woman's health care provider" in addition to your selection of a primary care physician. A Woman's Health Care Provider is a physician licensed to practice medicine in all its branches specializing in Obstetrics or Gynecology or specializing in Family Practice. A Woman's Health Care Provider may be seen for care without referrals from your primary care physician. If you have not already selected a Woman's Health Care Provider, you may do so now or at any other time. You are not required to have or to select a Woman's Health Care Provider.

Your Woman's Health Care Provider must be a part of your plan. You may get the list of participating Obstetricians, Gynecologists, and Family Practice specialists from your plan by calling 1-888-346-4968. The list will be sent to you within 10 days after your call. To designate a Woman's Health Care Provider from the list, call 1-888-346-4968 and tell our staff the name of the physician you have selected.

Your plan requires that your Primary Care Physician and your Woman's Health Care Provider have referral arrangement with one another. If the Woman's Health Care Provider that you select does not have a referral arrangement with your Primary Care Physician, you will have to select a new Primary Care Physician who has a referral arrangement with your Woman's Health Care Provider or you may select a Woman's Health Care Provider who has a referral arrangement with your Primary Care Physician. The list of Woman's Health Care Providers will also have the names of the Primary Care Physicians and their referral arrangements."

- B. Physician Incentive Plan:** You are entitled to request information regarding the Physician Incentive Plan. This is in compliance with Section 15(b) of the Patient's Rights Act and the state Medicaid Manual, Section 2087.9(B). To obtain this information, mail your request to Family Health Network, 910 W. Van Buren, Chicago, IL 60607.
- C. Transition of Care:** If you are a new enrollee and are in a treatment plan by a doctor who is not in the Family Health Network, you can ask to keep seeing that doctor for up to 90 days after becoming a member of Family Health Network under the following conditions:
 - You must keep seeing the same doctor regularly for treatment of the specific medical condition or disease.
 - You are in your seventh, eighth, or ninth month of pregnancy. You can ask to keep your doctor until after the baby is born and the follow-up care is completed.
 - Your doctor agrees to follow the Family Health Network policies and payment.

To request Transition of Care services, call the FHN Member Services at: 1-888-346-4968 and they will help you. If your care can be transitioned to an in-network provider safely, this will be done as soon as reasonably possible depending on your treatment plan.

Pre-Certification and Utilization Review

- Pre-certification is required for all non-emergent hospital admissions. Your PCP or WHCP must arrange the admission and his Medical Group must call FHN for Pre-certification approval.
- Pre-certification is required for all outpatient surgical procedures (Ambulatory Surgery). Your PCP or WHCP must notify the Medical Group by completing a referral form and submitting it to FHN for approval prior to the procedure.
- The member or a designee must notify FHN of all admissions to hospitals, other than the hospital named on the member ID card. This must be done within 48 hours.
- Utilization review will be done on a regular basis for all members admitted to a hospital. If you are not admitted to the network hospital listed on your card, you may be transferred to a network hospital after your medical condition is stable.
- Your PCP or WHCP must provide all follow-up care after hospitalization unless your PCP has given you a referral to receive care from a specialist.

Primary Care Physician Selection

At the time of enrollment you will be asked to select a PCP for each member of your Family enrolled in Family Health Network. You may also select a Woman's Health Care Provider. You may change your PCP and WHCP at any time. It may take up to 30 days for the change to become effective.

Access to Specialty Care

Your PCP will determine when specialty care is required. He will arrange for you to see a specialist by giving you a referral form describing the services the specialists may perform. After the specialty visit has occurred, the specialists and your PCP will determine the best course of action for your health care needs. Your PCP will notify you of additional tests and procedures, which should be done. In some cases it will be necessary to have tests and/or procedures done at facilities where contractual arrangements exist. You must have an authorized referral form for any specialty physician visits and/or tests. If you need transportation for these specialty services, contact Member Services at least one (1) business day in advance.

Family Planning Services

You can access Family Planning services in-network AND out-of-network without a referral from your PCP. Family Planning services are FREE.

Section X: Advance Directives (Living Will)

An advance directive is a formal document, written by you in advance of a disabling illness or injury. As your health care provider, FHN is required by law to inform you of your rights to make health care decisions and to execute advance directives. As long as you can speak for yourself, FHN will honor your wishes. But, if you become so sick that you cannot speak for yourself, an advance directive will guide your health care providers in treating you and will save your family, friends and physicians from having to guess what you would have wanted. There are several types of advance directives you can choose from including:

- Durable Power of Attorney for Health Care
- Living Wills, and
- Natural Death Act Declarations.

It is necessary that you provide copies of your completed directive to:

- Your Primary Care Physician
- Your agent
- Your family

Be sure to keep a copy with you and take a copy to the hospital. You are not required to have an advance directive and you will not be denied care if you do not have an advance directive. If you have questions, talk to your PCP.

Section XI: Complaint and Grievance Procedure for Clinical and Non-Clinical Issues

If you have a complaint or concern, read and proceed with the following procedures to resolve it.

A. Grievance Procedure – Non-Clinical

Grievance filers may utilize this process for a variety of reasons including, but not limited to, problems/complaints concerning providers, non-clinical issues, quality of care issues, or physician access issues.

Grievance - An expression of dissatisfaction about any matter other than an action that is properly the subject of an appeal. Subjects for grievances include, but are not limited to, quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Action includes the following:

- The denial or limitation of authorization of a requested service, including the type and level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- Failure to respond to an appeal in a timely manner

Grievance filer – A member, the parent/guardian of a minor member, or a guardian, caretaker relative, PCP, WHCP, or other physician treating the member that may be appointed in writing by the member to represent him or her throughout the grievance and appeal process.

Procedure:

Informal Review and Resolution

1. Grievance filers may bring grievances to FHN by telephone, in person or in writing. FHN will provide assistance to the grievance filer as needed to follow the grievance procedures, including interpreter services.
2. FHN medical groups will refer any grievances they receive to FHN.
3. FHN Member Service Representatives are knowledgeable about this procedure and are able to connect callers to the appropriate person at

FHN at the time of the initial call.

4. FHN Member Service Representatives are English/Spanish speaking and have access to the AT&T language bank at 1-800-874-9426 for other language speakers. There is a TDD phone for use by the hearing impaired as well as access to sign language interpreters through the Chicago Hearing Society at 312-934-6888.
5. FHN will attempt to resolve the grievance informally during the initial contact with the grievance filer but no longer than three (3) business days after the receipt of the grievance.
6. FHN Department managers have the authority to initiate corrective actions and effect resolutions for issues pertinent to their departments. FHN staff involved in any previous level of review or decision-making will not be allowed to make decision(s) concerning the grievance.
7. The grievance filer is notified of the resolution within three (3) business days. Notification may be by telephone unless the grievance filer requests written notification.
8. Member Services representatives will create a call log for all grievance calls documenting the date and time of receipt of the grievance as well as the reason for the grievance.
9. Grievances that are resolved within three (3) business days of receipt will have the resolution documented in the call log. Telephonic notification to the grievance filer of the resolution will be documented in the call log. Grievance filers that cannot be contacted by telephone within the three (3) day timeframe will be notified in writing of the resolution of their grievance.
10. Should the member remain dissatisfied, the member may file a formal grievance in writing.

Formal Grievance Procedure

1. Formal grievances must be in writing and submitted to the Grievance Committee except quality of care or clinical grievances, which will be submitted to the QA/UM or Peer Review Committees for resolution.

2. The grievance filer will be notified in writing of the receipt of their grievance within three (3) business days of the receipt of the grievance.
3. The Grievance Committee will be composed of at least 25% representation by FHN enrollees. HFS may require that one member of the Committee be a representative of HFS. This committee will resolve only non-clinical issues.
4. The Director of UM/QM, Director of Network Development and the VP of Operations and one FHN enrollee will compose the committee. Alternate members include the Director of Marketing and the Manager of Member Services. Members on the committee have the authority to require corrective action.
5. Formal grievances must be resolved within fifteen (15) business days of receipt of the grievance.
6. The fifteen (15) day resolution timeframe may be extended up to fourteen (14) days if:
 - The grievance filer requests the extension.
 - FHN shows HFS there is a need for additional information and that the delay is in the member's interest.
7. The grievance filer will be notified of the extension in writing within three (3) business days (if the grievance filer did not request the extension).
8. The Grievance Committee will meet no less than quarterly and as needed to meet resolution timeframes for grievances heard by the committee.
9. As membership on the Grievance Committee is voluntary, rules of evidence are not followed.
10. The Grievance Committee will meet at FHN or other location convenient for the grievance filer. In no event will the distance to the meeting be unreasonably long for the grievance filer.
11. The grievance filer will be allowed to present their grievance to the Committee at the meeting.
12. After the Grievance Committee meeting, the Committee will report its decision to the grievance filer, other pertinent parties, FHN, and Medical Group within ten (10) business days in writing. The written notification will clearly and in easily understandable language state the determination of the committee.
13. The decision of the Grievance Committee is binding on FHN and the Medical Groups.
14. In addition to hearing formal grievances, the Grievance Committee will also review the grievance log for identification of trends and/or patterns needing further action and to verify that timeframes have been met.
15. If the grievance filer remains dissatisfied, the grievance filer may appeal directly to HFS under its Fair Hearing system not less than twenty (20) or more than ninety (90) days from the date of the grievance resolution letter. Both FHN and the grievance filer will be entitled to submit

statements setting forth their positions. The decision by HFS is final and binding. The letter notifying the grievance filer of the grievance determination will include notification of the right to access the HFS Fair Hearing system. Mail request to:

**HFS Bureau of Administrative Hearings
Fair Hearing System
401 S. Clinton Ave, 6th Floor
Chicago, IL 60607-3800**

Expedited Grievance Procedure

1. An expedited grievance may be filed if the member's health so necessitates.
2. Acknowledgement of the receipt of an expedited grievance, including the information required by FHN to process the grievance will be made orally to the grievance filer no later than twenty-four (24) hours after the receipt of the request for expedited grievance.
3. Determination will be made within twenty-four (24) hours of receipt of all necessary information.
4. Expedited decisions will be made by the FHN Medical Director or other physician for quality of care issues or by the appropriate FHN administrator for non-quality of care issues.
5. The grievance filer and other pertinent parties will be notified orally within twenty-four (24) hours of the determination.

Additional Procedures

1. FHN will include this process in its member handbook and provider manual.
2. This policy will be reviewed annually and any subsequent changes and/or amendments will be submitted to HFS in writing for approval prior to implementation.
3. All grievances will be categorized into the major categories of Clinical/Medical Care issues, Access to providers (includes transportation), Claims, Administrative (includes ID cards, member handbook, extra benefits, eligibility issues, Brighter Beginnings, and Weight Watchers), Marketing, and Member Services.
4. All potential quality of care and clinical issues will follow the formal grievance process and will be handled through the PR or QA/UM Committees.
5. FHN will keep a grievance log on file.
6. A summary of all grievances and the disposition of the grievance will be submitted to HFS quarterly.
7. The FHN QA/UM the Grievance Committees will review the log for trends/issues that may require further monitoring.
8. This policy is not to be used for alleged malpractice.

B. Appeal and External Independent Review Procedure – Clinical:

Action includes the following:

- The denial or limitation of authorization of a requested service, including the type and level of service
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- The failure to provide services in a timely manner
- Failure to respond to an appeal in a timely manner

Appeal filer – A member, the parent/guardian of a minor member, or a provider acting on behalf of the member and with the member’s written consent have authority to file an appeal.

Procedure:

Formal Appeal Procedure

1. Within ninety (90) days of the notification of an action, an appeal filer may appeal orally or in writing. Oral requests for appeal must be followed by a written signed request for appeal, if not a request for an expedited appeal.
2. The appeal filer may present evidence orally or in writing to support their appeal request.
3. The appeal filer will have the opportunity any time during the appeal process to examine the member’s case file.
4. The FHN Medical Director or other qualified medical professional will review the medical records and make a determination. The determination is documented and kept on file with the medical record.
5. The medical professional reviewing the appeal will not have been involved in the initial denial/action.
6. The appeal reviewer will have appropriate clinical expertise in treating the member’s condition or disease.
7. If the action does not significantly increase the risk to the member’s health, FHN will make a determination within fifteen (15) business days of receipt of all information needed to make the determination.
8. The time frame for resolution for both standard and expedited appeals may be extended by fourteen (14) calendar days if:
 - The member requests the extension
 - FHN shows there is need for additional information and the delay is in the member’s interest
9. If the extension is requested by FHN, the appeal filer will be given written notice of the reason for the delay.

10. The member, PCP, other involved provider(s) and Medical Group will be informed of the results of the appeal orally followed by written confirmation for expedited appeals within two (2) business days after determination is made and by written notification only within five (5) business days for all other appeals.

11. The appeal letter includes clear and detailed reasons for the determination, the criteria used as the basis for the determination in easily understood language, the date the appeal was completed, and the procedure for requesting an external independent review. The appeal letter also includes language notifying members of their right to request to receive benefits while the external independent review is pending and that the member may be held liable for the cost of those benefits if the external independent review upholds FHN’s decision. A copy of the letter is kept with the medical records.

12. If the appeal results in the approval of previously denied service and the claim is on file at FHN, FHN will re-adjudicate the claim. If the claim is not on file, the provider will be asked to submit a claim.

13. If the member and/or provider(s) are dissatisfied with the result of the appeal due to a medical necessity denial, they may request an external independent review.

14. If the member and/or provider(s) are dissatisfied with the result of an appeal for denials for any reason other than medical necessity, they may appeal to HFS’ Fair Hearing Process (see #7 under “External Independent Review Procedure”).

Expedited Appeal Procedure

1. An expedited appeal may be requested if the member’s health so necessitates.
2. Acknowledgement of the receipt of an expedited appeal, including the information required by FHN to process the appeal will be made orally to the appeal filer no later than twenty-four (24) hours after the receipt of the request for an expedited appeal.
3. Determination will be made within twenty-four (24) hours of receipt of all necessary information.
4. The appeal filer and other pertinent parties will be notified orally within twenty-four (24) hours of the determination.
5. A fourteen (14) day extension may be requested as per number 9 in the previous section.

External Independent Review Procedure

1. FHN will strive to resolve all external independent reviews in the most expeditious manner and provide notice of the determination no more than twenty-four (24) hours after receipt of all necessary information when a delay would significantly increase the risk to a member's health or when extending health care services for a member currently undergoing a course of treatment are at issue.
2. Within thirty (30) days of receipt of written notice of adverse determination of an appeal, appeal filer may decide to initiate an external independent review. The appeal filer, on behalf of a member, shall send written request for an external independent review to FHN.
3. Within thirty (30) days of receipt of the request for external independent review, FHN shall:
 - Forward to the external independent reviewer all medical records and supporting documentation, a summary description of applicable issues including a statement of FHN's decision, the criteria used and the medical and clinical reasons for the decision.
4. Within five (5) days after receipt of all necessary information, or within twenty-four (24) hours for an expedited review, the external independent reviewer shall evaluate and analyze the case and render a decision. The decision of the external independent reviewer is final.
5. The appeal filer and all other pertinent parties will be notified in writing within five (5) business days of the results of the external independent review.
6. If the external independent review determines that the service(s) in question are medically appropriate, the service(s) will be paid for provided the services are considered eligible covered services by HFS.
7. The appeal filer may further appeal an adverse decision by the external independent reviewer to HFS under its Fair Hearing System. The appeal filer must submit this request to HFS no less than twenty (20) or greater than ninety (90) days from the date of the letter informing the enrollee of the results of the external independent review and this process is included in that letter. The decision by HFS is final and binding. Request is mailed to:

**HFS Bureau of Administrative Hearings
Fair Hearing Process
401 S. Clinton Ave, 6th Floor
Chicago, IL 60607-3800**

Additional Procedures

1. FHN will be solely responsible for paying the fees of the external independent review.
2. This procedure is included in the FHN Provider Handbook.
3. This policy will be reviewed annually and any subsequent changes and/or amendments will be submitted to HFS for approval prior to implementation.
4. FHN will keep a log of appeals and external independent reviews.
5. A summary of all cases submitted for external independent review and the responses and disposition of the cases will be submitted to HFS quarterly.
6. Potential quality issues identified through the appeal and/or external independent review processes will be referred to the QA/UM or PR Committees as appropriate.
7. The FHN QA/UM Committee will review logs for trends/issues that may require further monitoring.
8. This policy is not to be used for alleged malpractice.

FAMILY HEALTH NETWORK PRIVACY NOTICE

The law requires Family Health Network (FHN) to protect the privacy of your medical information. This notice explains how FHN can use or share the medical information that FHN has about you or your family. It also explains your rights.

FHN must receive and keep your medical information so you can receive your healthcare. FHN may contract with other organizations or individuals to help provide your health benefits. These contractors may also receive and keep your medical information.

FHN may use or share your medical information without your permission for the reasons below.

- So you can get medical care. For example, FHN may share your medical information with your doctor or pharmacy so that they can give you medical care and the right medicine.
- So FHN can pay your medical bills. For example, FHN may use and share your medical information so your doctor can send a bill to FHN and so FHN can pay your medical bills. FHN may also use or share your medical information to recover payment from other medical insurance or benefits you may have.
- So FHN can perform its duties. For example, FHN may use or share your medical information to assess quality of care; to decide who is eligible for medical benefits; to manage your care; to direct and plan FHN's programs and budget; to coordinate with another public benefit program; or for audits.
- To tell you about other health services. For example, FHN may call or write to tell you about treatment options or other health-related services.
- To comply with the law. For example, the law requires FHN to allow the Illinois Department of Public Aid to audit FHN records. FHN may share your medical information to comply with other laws.
- For other reasons. Examples include:
 - To comply with legal proceedings, such as a court or administrative order or subpoena;
 - To enforce other laws or protect someone's health and safety;
 - So a family member, friend or other person can help you to get or pay for your health care;
 - So a personal representative you appoint or a court appoints for you can help you get health benefits;
 - To support research as long as the information will be protected by the researchers;
 - So a coroner or medical examiner can identify a deceased person or cause of death or so a funeral director can arrange burial;
 - To support an organ procurement organization in limited circumstances;
 - To protect you against a serious threat to your health or safety or the health or safety of others;
 - To support a government agency overseeing health care programs;
 - For lawful national security purposes;
 - For public health purposes; and
 - For military purposes, if you are a member of the armed forces.

FHN will not use or share your medical information for any other reason unless you give FHN written permission. You may withdraw your permission in writing at any time. However, if FHN used or shared your information for a long-term project like a research study, FHN may continue to use or share your information for that purpose only. Your permission for FHN to use or share your information will end when FHN gets your written notice to withdraw your permission.

Your rights. You may ask FHN to do any of the following if you ask in writing. FHN will decide if we can fulfill your requests. FHN will write our decision in a letter to you.

- You may ask FHN not to use or share your medical information. FHN does not always have to agree.
- You may ask FHN to contact you about your medical information privately in a different way or at a different place than FHN is currently doing. FHN does not always have to agree unless the change is necessary to protect you, and FHN can still pay your medical bills. When you write to ask for this change, you must tell FHN how to contact you in private.
- You may ask to see or get copies of your medical information. You may be charged a small fee for copies.
- You may ask FHN to correct your medical information. FHN does not always have to agree to make the change.
- You may ask for a list of the ways FHN shared your medical information for up to 6 years.
- You may write to ask FHN to send you another copy of this Notice.

If you want any of these things, contact the FHN Privacy Officer. FHN will help you make your written request.

Complaints. If you believe FHN has not protected your right to privacy, you have the right to complain to FHN or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with FHN. FHN will not hold it against you if you file a complaint.

Plan: Family Health Network
Toll Free Telephone Number: 1-888-346-4968

Basics	Your Doctor <i>(description of process for selection of physician, PCP and/or WPHCP)</i>	Choose your PCP during enrollment. Choose your WHCP at any time. Call Member Services to change your PCP or WHCP.		
	Annual Deductible (if applicable)	Not Applicable		
	Out of Pocket Maximum	<i>Individual</i>	Not Applicable	
		<i>Family</i>	Not Applicable	
	Lifetime Maximums (if applicable)	Not Applicable		
	Pre-existing Condition Limitations	None		
		Description of Coverage	Health Care Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care	Authorized Days	100%	0
	Room & Board	Authorized	100%	0
	Surgeon's Fee	Authorized	100%	0
	Doctor's Visits	PCP and Auth. Specialty	100%	0
	Medications	Ill Medicaid Formula	100%	0
	Other Miscellaneous Charges	Authorized	100%	0
	Emergency Services - <i>(medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.)</i>	Covered	100%	0
	Emergency Post-stabilization services	Covered	100%	0
In the Doctor's Office	Doctor's Office Visits	PCP & Auth. Specialty	100%	0
	Routine Physical Exams	Covered	100%	0
	Diagnostic Tests and X-rays	Authorized	100%	0
	Immunizations	Covered	100%	0

	Allergy Treatment & Testing	Authorized	100%	0
	Wellness Care	Covered	100%	0
	Outpatient Surgery	Authorized	100%	0
	Maternity Care	<i>Hospital Care</i>	Covered In Contracting Area	100%
		<i>Physician Care</i>	Covered In Contracting Area	100%
	Mental Health	<i>Outpatient</i>	Self Referred Network Providers Only	100%
		<i>Inpatient</i>	Self Referred Network Providers Only	100%
	Substance Abuse	<i>Outpatient</i>	Self Referred Network Providers Only	100%
		<i>Inpatient</i>	Self Referred Network Providers Only	100%
	Outpatient Rehabilitation Services	Authorized	100%	0
Other Services	Durable Medical Equipment	Authorized	100%	0
	Hospice	Authorized	100%	100%
	Home Health Care	Authorized	100%	100%
	Prescription Drugs	Not Covered	N/A	N/A
	Dental Services	Not Covered	N/A	N/A
	Vision Care	Not Covered	N/A	N/A

Primary Care Physician Selection

* Routine delivery outside the Contracting Area is not covered. If you leave the services area during your third trimester, talk to your doctor first or call Family Health Network for information. Family Health Network may not pay for your delivery if you are outside the service area.



FAMILY HEALTH
NETWORK

910 W. Van Buren, 6th Floor
Chicago IL 60607

