# Table of Contents

Welcome Letter .................................................................................................................. 3  
Key Features ..................................................................................................................... 4  
Meridian Service Area ........................................................................................................ 5  
About Meridian .................................................................................................................. 6  
Population Management ..................................................................................................... 7  
Quality Management .......................................................................................................... 8  
Eligibility ............................................................................................................................. 8-9  
Enrollment .......................................................................................................................... 9  
Covered Benefits .................................................................................................................. 10  
Meridian Enhanced Member Benefits ............................................................................... 10  
HEDIS® Bonus Program ...................................................................................................... 11  
Meridian Outreach ............................................................................................................. 12  
Avoid Missed Opportunities ............................................................................................... 13  
Meridian Website ................................................................................................................ 14  
Meridian Provider Portal .................................................................................................... 14  
Referral Pre-Service Clinical Review Program .................................................................... 15  
Authorization Referral Forms ............................................................................................. 16-17  
Authorization Overview ...................................................................................................... 18-19  
Claims & Payment Information ............................................................................................ 19  
Billing Information .............................................................................................................. 20  
Fraud, Waste & Abuse ........................................................................................................ 21-22  
Meridian Medicare ............................................................................................................. 23-26  
Meridian Contact Information ............................................................................................. 27
Dear Provider,

It is my pleasure to introduce you to Meridian Health Plan. As a licensed HMO in the State of Iowa, we know our success is based on the relationships that we have with our providers. It is for this reason that we focus on offering an elevated level of customer service to our contracted providers with an increased focus on the quality of care that our members receive.

Sincerely,

David B. Cotton, M.D.
David B. Cotton, MD
President/CEO
Meridian Health Plan
Timely claims processing
• Meridian pays clean claims in a timely manner
• Electronically billed claims are paid faster

Simplified administration and authorization process
• Secure, online Provider Portal allows providers to view member eligibility, enter authorizations, verify claims status, request direct assistance from Case Management and Member Services and review member health history, including previous utilization from other health plans
• Majority of routine outpatient surgeries do not require prior authorization
• Authorizations are not needed for physician visits, clinic visits (RHC and FQHC), diagnostic labs or x-ray (including MRI, CT scan, etc.)

Incentive programs
• Generous incentives based on HEDIS measures ranging between $20 and $200 per service
• Paid over $15 million in quality bonuses to participating providers in 2014

Hassle-free policies and procedures
• Meridian will reimburse PCPs for well and sick visits provided during the same visit
• Meridian pays the co-pays so physicians do not have to collect them

Additional Benefits
• Providers do NOT have to accept new members! Just keep providing services to the current Iowa Medicaid members
• Provider offices will have an assigned local Provider Network Development Representative that will be able to respond to any issues that may arise

Meridian Health Plan
• Physician owned and operated
• Serving more than 55,000 members in 52 Iowa counties
• Provider network featuring 93 hospitals, over 2,500 PCPs and over 5,300 specialists
Meridian Health Plan is a Medicaid HMO in the State of Iowa providing healthcare to eligible enrollees through a contract with the Iowa Department of Human Services.

Revised: July 8, 2015
About Meridian

Our Mission:
To continuously improve the quality of care in a low resource environment

Our Vision:
• To be the #1 Medicaid Health Plan in Iowa based on quality, innovative technology and service to our members
• To be the premier service organization in government healthcare

Corporate History
Meridian Health Plan was formed from the merger of two plans, Central Michigan Health Plan (CMHP) and American Preferred Provider Plan of Michigan (APPPM). In August 1997, Dr. David B. Cotton acquired a majority position in CMHP and assumed fiscal and administrative responsibility for the plan, which had approximately 1,400 members. CMHP acquired APPPM in January 1999 and ultimately became operational as Health Plan of Michigan (HPM) in May 1999.

Operating as a full service HMO since January 2000, HPM obtained NCQA accreditation in May 2002 and URAC accreditation in March 2011. On January 1, 2012, Health Plan of Michigan became Meridian Health Plan. The name change represents Meridian's expanding horizons, yet the plan remains a physician-owned and physician-managed health plan.

Meridian began serving Iowa in March 2012, bringing its extensive experience from the Michigan and Illinois Medicaid markets to the state. Meridian has grown county-by-county throughout Iowa to its current service territory and continuously works to expand its network with intentions to service all 99 counties in Iowa.

Meridian's Michigan affiliate holds Excellent Health Plan Accreditation through the National Committee for Quality Assurance (NCQA), while the Illinois and Iowa affiliates earned Commendable Health Plan Accreditation through NCQA. Iowa achieved this accreditation status for the first year of service in the state. Meridian Health Plan of Michigan, Meridian Health Plan of Illinois and Meridian Health Plan of Iowa were ranked the #1 Medicaid HMO in their respective states by the NCQA Medicaid Health Insurance Plan Rankings 2014-2015.

To learn more about Meridian Health Plan, please visit www.mhplan.com.

Service Description
Meridian Health Plan’s philosophy is to function as a care management and preventive care organization with an emphasis on disease management. Meridian provides Medicaid covered benefits to our members based on the State of Iowa Medicaid benefit guidelines. These benefits include preventive care, physician office visits, diagnostic tests, home health care, inpatient hospital care, emergency room treatment and many other services to help our members stay healthy.
Member Outreach
Each new member receives a welcome call to verify Primary Care Provider selection, explain Meridian’s managed care processes and perform a Health Risk Assessment. In addition, members receive periodic telephone calls to remind them of important preventive services such as well-child visits, immunizations, prenatal care and other screenings.

Health Risk Assessment (HRA)
Members are contacted via mail and phone to complete the HRA. Based on the results of the HRA, members are assigned to Disease Management programs or Case Management services, as appropriate. Members not acute enough to require Case Management are screened for required preventive services. They are contacted through Meridian’s healthy outreach program and are actively encouraged to obtain the necessary care.

All of the data gathered through these activities is captured in Meridian’s state-of-the-art Managed Care System (MCS). This data collection supports a comprehensive approach to preventive care and health management for our members and providers.

Care Coordination
Meridian Care Coordination integrates the behavioral and physical needs of the member and coordinates referrals to maximize treatment success and outpatient care services. The Meridian Care Coordination model seeks to accomplish this by:

• Focusing attention on the individual needs of members
• Promoting and assuring service accessibility
• Maintaining communication with the member/caregiver, providers and community
• Identifying and removing barriers through collaboration with the PCP, specialists, member and family to develop a plan of care
• Integrating behavioral health and specialty care into care delivery
• Educating members on condition management, appropriate use of services and self-care techniques

Members enrolled in Care Coordination are stratified based on claims, historical and HRA data and are assigned to an acuity level of one through three, with three being the most complex. Target populations include:

• Pregnant members at all acuity levels
• Adults and children with special needs
• High-risk and high-cost populations with multiple health and social needs
• Members requiring post-hospitalization assessment and follow up
• High ER utilizers requiring education and communications with PCP
• Members with medical needs who are also suffering from psychosocial and behavioral health risk factors

Providers may refer members to Care Coordination by clicking the “Notify Health Plan” button within our Provider Portal, or by calling Meridian at 877-204-9072.
Quality Management

**Commitment to Quality**

Meridian Health Plan uses the nationally recognized Healthcare Effectiveness Data and Information Set (HEDIS(R)) to compare and benchmark Meridian Health Plan among other health plans servicing the Medicaid population. Meridian has made HEDIS improvement a corporate priority, with a goal of maintaining the status of #1 Medicaid HMO in Iowa based on HEDIS performance.

Throughout the year, Meridian monitors its HEDIS performance and conducts improvement activities to meet its goals, including education and outreach to members and providers.

For additional information regarding the Quality Improvement Program see HEDIS Bonus Program on page 11.

**Eligibility**

Individuals eligible for Meridian Health Plan will meet state Medicaid requirements, and also reside in a county that currently offers the MediPASS program. Individuals that qualify for Meridian are Iowa Medicaid managed care-eligible enrollees.

- Children under the age of 21
- Parents living with a child under age 19
- Women who are pregnant
- 19-64 years old earning <100% of the Federal Poverty Level (FPL)

Meridian members are provided with a Meridian Health Plan ID Card that is specific to the individual enrolled in the plan. The Meridian Health Plan Member ID number will mirror the Medicaid personal ID number on the Medical Assistance Eligibility Card that recipients also receive from the Department of Human Services. A member may replace a lost card by contacting Meridian’s Member Services department; a new card will be issued immediately.

Meridian offers two Medicaid products in Iowa:

**Meridian Health Plan**: Provides health care services to Medicaid beneficiaries based on the State of Iowa Medicaid benefit guidelines under the Temporary Assistance for Needy Families (TANF) program.

**Meridian Wellness Plan**: Part of Medicaid expansion, provides care to eligible Iowa residents who have an income at or below 100% of the federal poverty level but do not qualify for standard Medicaid.
Eligibility

All Meridian Health Plan members are issued an ID card upon enrollment:

Members are asked to present this card at each appointment. You may verify eligibility via the Meridian Provider Portal, ELVS (the Iowa Medicaid Portal) or by calling the Meridian Member Services department at 877-204-9132.

Eligibility cards should be viewed and verified at each encounter.

PCPs will have access to their monthly enrollment via the Meridian Provider Portal at any time.

No Co-Pays

Instead of lowering your reimbursement and burdening your office with the responsibility of collecting co-pays, Meridian has made the decision not to implement medical co-pays for our Medicaid members in cooperation with our provider partners.

Enrollment

Medicaid recipients wishing to enroll in Meridian Health Plan may contact Iowa Medicaid Member Services at 800-338-8366.
Covered Benefits

Meridian Health Plan covers the same scope of benefits under the Iowa Medicaid Program. Individuals choosing to enroll in Meridian Health Plan will not experience a loss of health care coverage or benefits.

Meridian enrollees will use their Iowa Medical Assistance Eligibility Card for the following services:

- Dental
- Pharmacy
- Non-emergent medical transportation
- Skilled nursing facilities
- Behavioral Health Services, including:
  - Mental Health Services
  - Substance Abuse Services
  - Psychiatric Institution Services
- Services by Area Educational Agencies
- Home and Community-Based Waiver Services

These services will continue to be reimbursed through the Iowa Medicaid Program.

Meridian Enhanced Member Benefits

No Co-Payments for covered medical services

Healthy Reminders Program
- An outbound phone outreach program designed to remind members of important preventive health services
- Reminder postcards and educational newsletters mailed to members

Health Awareness Program
- Prenatal Case Management
- Assistance in finding an OB/GYN, appointment reminders, educational mailings and outreach calls

Disease Management Programs
- Meridian helps members better understand and manage their chronic health conditions
Meridian Health Plan offers a HEDIS Bonus Plan for all contracted Primary Care Providers. The yearly bonus period will cover all HEDIS services provided between dates of service January 1, 2015 and December 31, 2015. These services must be reported to Meridian on a claim form or via fax by February 28, 2016 in order to be eligible for a bonus payment. Providers may also submit HEDIS service information through Meridian’s secure Provider Portal.

To qualify for a bonus payment, the service must be delivered in strict accordance with HEDIS guidelines. Services which are delivered, but do not meet strict HEDIS guidelines, will not be eligible for a bonus. HEDIS guidelines are attached for the bonus measures. Time frames and enrollment criteria for each measure must be met.

Bonuses will be paid in four installments. The first payment will be made at the end of April 2015, followed by a payment at the end of July 2015, the end of October 2015 and the final payment during March 2016.

Meridian will provide each PCP with a monthly HEDIS report, either electronically through the Meridian Provider Portal or hard copy. The report will list all members who require a HEDIS service. Specifically, childhood members needing immunizations will remain on the list until all immunizations are received, or the second birthday passes. Childhood members requiring well-child visits will remain on the list until all six visits are received, or until the 15-month birthday passes. If members change PCPs but are still enrolled with Meridian, they will show on the new PCP lists.

In addition, Provider Network Development Representatives will meet with each practice to answer questions and assist in developing a plan to ensure Meridian members receive these very important services.

Meridian is committed to ensuring that our members receive quality preventive health care.
Meridian Outreach

Meridian Health Plan wants to make sure that all of our members receive the preventive care they need. In order to demonstrate our commitment, Meridian has dedicated significant resources to member outreach programs.

All of these efforts result in higher HEDIS scores and help our providers obtain their incentive bonuses.

This summary of Meridian's outreach efforts demonstrates our commitment to quality:

- Meridian's Member Outreach Team places phone calls to Meridian households to remind them of important preventive services, including:
  - Well-Child and Adolescent Visits
  - Blood Lead Testing
  - Diabetes Testing (HbA1c, LDL, Eye Exams)
  - Child and Adolescent Immunizations
  - Breast and Cervical Cancer Screenings

- On every call, the member outreach specialists verify the member’s demographic information and PCP selection in addition to providing outreach reminders
- Approximately 30% of members have a HEDIS hit with a date of service after receiving a Meridian outreach call
- Meridian mails outreach postcards to members reminding them of important preventive services
- Incentives are distributed to members for obtaining preventive health services (gift cards)
- Meridian sponsors and participates in community events, including health fairs and lead screening fairs

The Meridian Provider Services department can work with PCP offices to design a targeted mail outreach program especially for your patients. Your assigned Provider Network Development Representative will coordinate these outreach efforts with your office.

Charitable Activities

Meridian Health Plan is committed to and engaged with our local communities and the State of Iowa. Our donations of time and dollars demonstrate the commitment of Meridian Health Plan and its employees to fostering programs that improve the quality of care in a low resource environment.
According to the National Committee for Quality Assurance (NCQA) and HEDIS® specifications, infants need at least six well-child visits between the ages of 0 and 15 months. Children between the ages of 3-6 years and adolescents between the ages of 12-21 years need one well-child visit every year. A well-child visit includes these three components:

- Health and developmental history (physical and mental)
- Physical exam
- Health education/anticipatory guidance

What is a Missed Opportunity?
Meridian Health Plan wants providers to avoid missed opportunities. Take advantage of every office visit to provide the preventive health services our members need, including well-child visits, immunizations and lead testing. Here are some tips to maximize those visits:

**Turn a Sick Visit into a Well-Child Visit**
Meridian Health Plan will reimburse providers for a well-child visit and a sick visit performed on the same day. Simply add a modifier 25 to the sick visit and bill for the appropriate well visit.

**Turn a Sports Physical into a Well-Child Visit**
Many children request sports physicals annually to participate in school and community activities. Just add anticipatory guidance to the sports physical's medical history and physical exam, and you can turn it into a well-child visit.

**Make Every New Patient Visit a Well-Child Visit**
New patients usually require a health and developmental history and a physical exam. Add some health education, and you have provided a well-child visit. Include the V20.2 diagnosis code to your claim, along with the appropriate CPT code for the new patient visit.

**Don’t Wait a Year for the Next Well-Child Visit**
Meridian pays for one well-child visit per calendar year. The visits do not have to be 12 months apart, or coincide with the child’s birthday. For example, if you provided a well-child visit in October 2011 and the child is back in your office in June 2012, you can provide a well-child visit and Meridian will reimburse you.

**Meridian Offers a Quality Incentive Bonus for Well-Child Visits**
For every well-child visit performed on an assigned member in accordance with HEDIS specifications, providers will receive a bonus payment of $25.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>HCPCS Codes</th>
<th>CPT Codes</th>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15 Months</td>
<td>G0438, G0439</td>
<td>99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461</td>
<td>V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>3-6 Years</td>
<td>G0438, G0439</td>
<td>99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461</td>
<td>V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
<tr>
<td>12-21 Years</td>
<td>G0438, G0439</td>
<td>99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461</td>
<td>V20.2, V20.31, V20.32, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9</td>
</tr>
</tbody>
</table>

Revised: July 8, 2015
The Meridian Health Plan website offers these features:

- Provider Manual
- Provider directory
- Bulletins
- Forms
- Useful links and information
- Live online chat services
- Plus much more

A Meridian-supplied user name is required for access. To sign up, please visit our website at www.mhplan.com/ia/mcs.

If you have any questions, please contact your Provider Network Development Representative.

Meridian Provider Portal

The Meridian Health Plan Provider Portal, available free for contracted providers, offers the following features:

- Verify eligibility for Medicaid members
- Authorizations
- Claims status and submission/correction
- Meridian member information and reports
- Enrollment lists
- HEDIS Bonus information
- HEDIS self-reporting
- Plus much more

www.mhplan.com/ia/mcs
Referrals
Referral processing is the primary activity performed by our Utilization Management staff. If you have a referral request or question, please contact our Utilization Management Department at 877-204-9072, and they will be glad to help you.

Meridian offers three easy ways to submit referrals:

1. Electronically, through Meridian's secure Provider Portal
2. By fax, 515-802-3560, to Utilization Management. Please include pertinent clinical documentation with the request if indicated
3. By phone for urgent requests. Please call Meridian's Utilization Management department at 877-204-9072. Make sure you identify the request as “urgent” to expedite the pre-service review process

Pre-Service Clinical Review Program
Meridian’s clinical staff must review select services before they are provided. Clinical review assists in determining whether the service is clinically appropriate, is performed in the appropriate setting, and is a covered benefit. Please forward the pertinent clinical information with your request via fax or through the Meridian Provider Portal to expedite a response.

Refer to the next page for the services that require clinical review.

Utilization Management (UM) clinical staff use plan documents for benefit determination and Medical Necessity Coverage Guidelines to support UM decision-making. All Utilization Review decisions to deny coverage are made by Meridian’s Medical Directors. In certain circumstances, external reviews of service requests are conducted by qualified, licensed physicians with the appropriate clinical expertise.

Provider Appeal
Providers may appeal a denial either before a service is rendered or after it is rendered. In the instance of a pre-service denial, Meridian’s nurse reviewer contacts the provider office by phone to inform them of the denial decision and the reason for the denial. The nurse reviewer also provides contact information to discuss the denial with Meridian’s Medical Directors.

Written denial notification is sent via fax and mailed to the member. Treating providers who would like to discuss a utilization review determination with the decision-making Medical Director may contact the Utilization Management Department at 877-204-9072.

The written denial notification will include the reason for the denial, the reference to the benefit provision and/or clinical guideline on which the denial decision was based, and directions on how to obtain a copy of the reference. You may contact the Utilization Management department at 877-204-9072 to request a copy of Meridian’s medical necessity guidelines.
## Iowa Referral Form

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone: ( ) -</th>
<th>DOB (MM/DD/YYYY): / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID#:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PCP NAME**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone: ( ) -</th>
<th>Fax: ( ) -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
<td></td>
<td></td>
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</table>

**SPECIALIST REFERRED TO**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Phone: ( ) -</th>
<th>Fax: ( ) -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start: / /</td>
<td>End: / /</td>
<td>Address:</td>
<td>Specialty:</td>
</tr>
</tbody>
</table>

**FACILITY/PROVIDER NAME**

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Phone: ( ) -</th>
<th>Fax: ( ) -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Service: / /</td>
<td>Address:</td>
<td></td>
</tr>
</tbody>
</table>

**SERVICES THAT DO NOT REQUIRE A PRIOR AUTHORIZATION**

- Allergy Testing
- Bone Density
- Chiropractic Services (up to 12 visits)
- ECG
- Life Threatening Services
- Mamogram & Pap
- OB/GYN Services
- Routine Lab
- Routine X-Ray
- (MRA, MRI, PET Scan, CT Scan)
- Sleep Studies (facility only)
- Stress Tests
- Ultrasounds
- Urgent Care
- Behavioral Health
- Psychiatric and Substance Abuse services in all settings are covered by Magellan Health Services of Iowa. Please call 800-638-8820 for information about these services or visit www.magellanofiowa.com.

**SERVICES THAT REQUIRE NOTIFICATION TO MERIDIAN HEALTH PLAN**

- Outpatient Radiation Therapy
- Dialysis
- Maternity Care/Maternal Support Services
- Observations

**SERVICES THAT REQUIRE A PRIOR AUTHORIZATION** (may require clinical information)

- Ambulance Transportation (non-emergent)
- Anesthesia when performed with Radiology Testing
- Bariatric Surgery
- Cardiac/Pulmonary Rehab
- Chiropractic Services (over 12 visits)
- Cosmetic, Reconstructive or Plastic Surgery
- DME/Prosthetics and Orthotics >$500
- Elective Inpatient Admission
- Elective Outpatient Surgery
- Genetic Testing/Sterilization
- Hearing Aids
- Home Health Care/Hospice/IV Therapy
- Pregnancy Termination
- Speech, Occupational and Physical Therapy

**SERVICES REQUESTED**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code</th>
<th>ICD 9/ICD 10 Code</th>
<th># of Visits Requested:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT Code</td>
<td>CPT Code</td>
<td>Comments:</td>
<td></td>
</tr>
<tr>
<td>CPT Code</td>
<td>CPT Code</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*All Emergency Inpatient Admissions require authorization from Meridian Health Plan. For authorization, Meridian must be notified within the first 24 hours or the following business day.*

By requesting prior authorization, the provider is representing that the services to be provided are medically necessary. As a condition of authorization for those services, the servicing provider agrees to accept no more than 100% of Iowa Medicaid rates. At no time will Meridian Health Plan pay more than 100% of Iowa Medicaid rates for any service. In the event that these services are deemed not to be medically necessary, Meridian Health Plan will not reimburse the provider for those services.
**Iowa Referral Form**

*Fax all Authorizations and clinical information to: 515-802-3560 or submit online at www.mhplan.com/ia/mcs*

**Pharmaceuticals Billed Under the Medical Benefit**

***Only one medication per request form. All fields must be complete and legible for review.***

Prior Authorizations cannot be completed over the phone.

<table>
<thead>
<tr>
<th>MEMBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name:</td>
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<tr>
<td>Member ID:</td>
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</table>

<table>
<thead>
<tr>
<th>PRESCRIBER INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriber Name &amp; Specialty:</td>
</tr>
<tr>
<td>Office Phone: (         ) -</td>
</tr>
<tr>
<td>Office Fax: (          ) -</td>
</tr>
<tr>
<td>Contact Person:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIAGNOSIS &amp; MEDICAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication:</td>
</tr>
<tr>
<td>Strength &amp; Route of Administration:</td>
</tr>
<tr>
<td>Frequency:</td>
</tr>
<tr>
<td>Height &amp; Weight:</td>
</tr>
<tr>
<td>Expected Length of Therapy:</td>
</tr>
<tr>
<td>Quantity:</td>
</tr>
<tr>
<td>BMI:</td>
</tr>
<tr>
<td>Date Calculated: / /</td>
</tr>
<tr>
<td>Diagnosis Related to Medication Request:</td>
</tr>
<tr>
<td>Blood Pressure:</td>
</tr>
<tr>
<td>Taken On: / /</td>
</tr>
<tr>
<td>Drug Allergies:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RATIONALE FOR PRIOR AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of medical condition, allergies or other pertinent information requiring the use of this medication:</td>
</tr>
</tbody>
</table>

Previous use of non-authorized and prior authorized medication tried and failed for this condition:

<table>
<thead>
<tr>
<th>Name of Medication:</th>
<th>Reason for Failure:</th>
<th>Date of Failure:</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

**You must include the most recent relative laboratory results to ensure a complete PA review.**

<table>
<thead>
<tr>
<th>Prescriber’s Signature:</th>
<th>Date: / /</th>
</tr>
</thead>
</table>

**Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return FAX) immediately and arrange for the return or destruction of these documents.
<table>
<thead>
<tr>
<th>Service Description</th>
<th>PCP/Specialist Notification to Meridian</th>
<th>Corporate Prior Authorization (May Require Clinical Information)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Testing</td>
<td><strong>Meridian Health Plan requests notification to communicate services with all providers involved, provide additional reporting services, and support efforts.</strong></td>
<td>Ambulance Transportation (Non-Emergent)</td>
</tr>
<tr>
<td>Annual Mammogram and Pap test</td>
<td><strong>Complex Outpatient Treatment</strong> - Chemotherapy, Dialysis, Outpatient Radiation Therapy</td>
<td>Anesthesia when performed with Radiology Testing</td>
</tr>
<tr>
<td>Audiology Services and Testing (excluding hearing aids)</td>
<td><strong>Maternity care/maternal support services</strong> - Notification is needed for OB referrals and for OB delivery</td>
<td>Bariatric Surgery</td>
</tr>
<tr>
<td>Barium Enema</td>
<td>First PCP/Specialist Notification is not necessary for claims payment. In-network or out-of-network practitioners will be reimbursed for consultations, evaluations, and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Iowa Medicaid and the Medicaid MCO Contract.</td>
<td>Cardiac/Pulmonary Rehab</td>
</tr>
<tr>
<td>Bone Densitometry studies</td>
<td>* Must be in compliance with 30 days federal notification requirement</td>
<td>Chiropractic Services (over 12 visits)</td>
</tr>
<tr>
<td>Bronchoscopy</td>
<td><strong>Behavioral Health, Psychiatric, and Substance Abuse services in all settings are covered by Magellan Health Services of Iowa. Please call 800-638-8820 for information about these services, or visit the Magellan website at <a href="http://www.magellantofiowa.com">www.magellantofiowa.com</a></strong></td>
<td>Cosmetic, Reconstructive, or Plastic Surgery</td>
</tr>
<tr>
<td>Cardiograph</td>
<td></td>
<td>Durable Medical Equipment, Prosthetic Devices, and Medical Supplies &gt; $1000 (e.g., augmentative enteral feeding device, enteral pump, communication devices)</td>
</tr>
<tr>
<td>Colposcopy after an abnormal Pap</td>
<td></td>
<td>Elective Hospital Outpatient Surgery</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetics Devices, and Medical Supplies ≤ $1000</td>
<td></td>
<td>Elective Inpatient Admissions/Surgeries</td>
</tr>
<tr>
<td>Electrocardiography (EKG)</td>
<td></td>
<td>Family Planning Services</td>
</tr>
<tr>
<td>Evaluation for Physical, Occupational and Speech Therapy</td>
<td></td>
<td>Hearing Aids</td>
</tr>
<tr>
<td>Gastroenterology Diagnostics</td>
<td></td>
<td>Home Health Care/Hospice/Infusion Therapy Services</td>
</tr>
<tr>
<td>Intravenous Pyelography (IVP)</td>
<td></td>
<td>Pain Management</td>
</tr>
<tr>
<td>Life-Threatening Emergencies — ER Screening</td>
<td></td>
<td>Pregnancy Termination</td>
</tr>
<tr>
<td>Mammography &amp; Pap smear</td>
<td></td>
<td>Specialty Drugs (covered under medical benefit) - e.g. Rituixin and Remicade (view a complete list at <a href="http://www.mhplan.com">www.mhplan.com</a>)</td>
</tr>
<tr>
<td>Myoview Stress Test</td>
<td></td>
<td>Weight Management (prior to Bariatric Surgery)</td>
</tr>
<tr>
<td>Neurology/neuromuscular diagnostic testing, including EEGs, 24-hour video EEGs and EMGs</td>
<td></td>
<td>All Emergency inpatient admissions require authorization from Meridian Health Plan.</td>
</tr>
<tr>
<td>Obstetrical Observations</td>
<td></td>
<td>In-network hospitals must notify Meridian within the first 24 hours or the following business day.</td>
</tr>
<tr>
<td>PT/OT/ST for 1st 24 visits age 21+</td>
<td></td>
<td><strong>Complex Outpatient Treatment</strong> - Chemotherapy, Dialysis, Outpatient Radiation Therapy</td>
</tr>
<tr>
<td>Routine Lab</td>
<td></td>
<td><strong>Maternity care/maternal support services</strong> - Notification is needed for OB referrals and for OB delivery</td>
</tr>
<tr>
<td>Routine X-ray including CT Scan, MRI, MRA, PET Scan, DEXA, HIDA Scansm, Bone Density</td>
<td>First PCP/Specialist Notification is not necessary for claims payment. In-network or out-of-network practitioners will be reimbursed for consultations, evaluations, and treatments provided within their offices, when the member is eligible and the service provided is a covered benefit under Iowa Medicaid and the Medicaid MCO Contract.</td>
<td></td>
</tr>
<tr>
<td>Neurology/neuromuscular diagnostic testing,</td>
<td>* Must be in compliance with 30 days federal notification requirement</td>
<td><strong>Behavioral Health, Psychiatric, and Substance Abuse services in all settings are covered by Magellan Health Services of Iowa. Please call 800-638-8820 for information about these services, or visit the Magellan website at <a href="http://www.magellantofiowa.com">www.magellantofiowa.com</a></strong></td>
</tr>
<tr>
<td>Non-Invasive Vascular Diagnostic Studies</td>
<td></td>
<td>For non-emergent medical transportation services, call 866-572-7662.</td>
</tr>
<tr>
<td>Obstetrical Observations</td>
<td></td>
<td>By requesting prior authorization, the provider is representing that the services to be provided are medically necessary. As a condition of authorization of those services, the servicing provider agrees to accept no more than 100% of Iowa Medicaid rates. At no time will Meridian Health Plan pay more than 100% of Iowa Medicaid rates for any services. In the event that these services are deemed not to be medically necessary, Meridian Health Plan will not reimburse the provider for those services.</td>
</tr>
<tr>
<td>Sleep Studies (facility only)</td>
<td></td>
<td>All services performed by out-of-network providers must receive prior authorization before the services may be performed for Medicaid members. Prior authorization does not apply for services required by EMTALA or for family planning related services.</td>
</tr>
<tr>
<td>SPECT Pulmonary Diagnostic Testing</td>
<td></td>
<td><strong>Out-of-network Hospitals must notify Meridian at the time of stabilization and request authorization for all post-stabilization services.</strong></td>
</tr>
<tr>
<td>Ultrasounds</td>
<td></td>
<td><strong>NON-COVERED BENEFITS</strong></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td>The following services are not covered benefits by Meridian Health Plan but may be reimbursed by the Iowa Medicaid Program:</td>
</tr>
<tr>
<td>Voiding Cysto-Urethrogram</td>
<td></td>
<td>Dental services, non-emergent medical transportation, services by area educational agencies,</td>
</tr>
<tr>
<td>Vision - 1 exam/yr; Lenses 4x/yr for ages 1-3, 1x/yr for ages 3-7, 1x/2 yrs for ages 8+</td>
<td></td>
<td>mental health/substance abuse/psychiatric services, and pharmacy benefits.</td>
</tr>
</tbody>
</table>
Prior PCP Notification
Meridian does not require PCP notification for Specialty Physician Referrals to in-network practitioners.

To reiterate, PCP notification is not required for claims payment.

In-network practitioners will be reimbursed for consultations, evaluations and treatments provided within the office setting, as long as the member is eligible and the service provided is a covered benefit under Iowa Medicaid and the Medicaid MCO Contract.

All services performed by out-of-network providers must receive prior authorization before the services may be performed for Medicaid members. Prior authorization does not apply for services required by EMTALA or for family planning related services.

Corporate Authorizations
Complete and fax Meridian Health Plan Referral Form to 515-802-3560 or access the online MCS Provider Portal with patient name, ID #, etc.

Claims Payments & Status
Meridian Health Plan is dedicated to processing your claims in a timely manner. You may status your claims several ways:

- Meridian’s secure Provider Portal at www.mhplan.com/ia/mcs
- Call or fax our Claims Department
  Tel: 800-203-8206
  Fax: 515-802-3570
- By Mail
  Meridian Health Plan
  Claims Department
  1001 Woodward Avenue, Suite 530
  Detroit, MI 48226

Claims Appeal Process
Meridian makes every reasonable effort to partner with our providers. In cases where a claim has been denied, providers may submit an appeal in writing. Please include the following:

- Patient name and ID#
- Reason for appeal
- Any relevant clinical information to support your appeal

The Meridian Appeals Committee meets regularly to review these appeals. You will receive a written response within 30 days.
Billing Information

Meridian Health Plan follows the state of Iowa Billing Guidelines, unless otherwise noted.

Mail to: Meridian Health Plan
1001 Woodward Avenue, Suite 530
Detroit, MI 48226

EDI Submission

The Payer ID is 13189.

Meridian Health Plan is currently accepting electronic claims from the following clearinghouses:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Customer Support</th>
<th>Claim Types</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>800-Availity</td>
<td>Professional/Facility</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
</tr>
<tr>
<td>PayerPath</td>
<td>877-623-5706</td>
<td>Professional</td>
<td><a href="http://www.payerpath.com">www.payerpath.com</a></td>
</tr>
<tr>
<td>EDI Support Services</td>
<td>800-967-7902</td>
<td>Professional/Facility</td>
<td><a href="http://www.edissweb.com">www.edissweb.com</a></td>
</tr>
<tr>
<td>Relay Health</td>
<td>800-527-8133</td>
<td>Professional/Facility</td>
<td><a href="http://www.relayhealth.com">www.relayhealth.com</a></td>
</tr>
<tr>
<td>Emdeon</td>
<td>800-845-6592</td>
<td>Professional/Facility</td>
<td><a href="http://www.emdeon.com">www.emdeon.com</a></td>
</tr>
<tr>
<td>SSI Group</td>
<td>800-880-3032</td>
<td>Professional/Facility</td>
<td><a href="http://www.thessigroup.com">www.thessigroup.com</a></td>
</tr>
<tr>
<td>Netwerkes</td>
<td>866-521-8547</td>
<td>Professional/Facility</td>
<td><a href="http://www.netwerkes.com">www.netwerkes.com</a></td>
</tr>
</tbody>
</table>
Health care fraud, waste and abuse affects every one of us. It is estimated to account for between 3% and 10% of the annual expenditures for health care in the U.S. Health care fraud is both a state and federal offense. Based on the HIPAA regulations of 1996, a dishonest provider or member may be subject to fines or imprisonment of not more than 10 years, or both (18 U.S.C. § 1347).

Fraud, waste and abuse are defined as:

**Fraud:** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 C.F.R. § 455.2)

**Waste:** Involves the taxpayers not receiving reasonable value for money in connection with any government funded activities due to inappropriate act or omission by player with control over or access to government resources (e.g. executive, judicial, or legislative branch employees, grantees, or other recipients). Waste goes beyond fraud and abuse and most waste does not involve a violation of the law. Waste relates primarily to mismanagement, inappropriate actions and inadequate oversight. (From the Inspector General)

**Abuse:** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. (42 C.F.R. § 455.2)

Here are some examples of fraud, waste and abuse:

**Fraud**
- Providers billing for services not provided
- Providers billing for the same service more than once (i.e., double billing)
- Providers performing inappropriate or unnecessary services
- The misuse of a Medicaid card to receive medical or pharmacy services
- Altering a prescription written by a doctor

**Waste**
- Providing a refill on a prescription when it is not known if it is necessary
- Prescribing a brand name drug when the generic is on the formulary

**Abuse**
- Going to the Emergency Department for non-emergent medical services
- Threatening or abusive behavior in a doctor’s office, hospital or pharmacy
Meridian Health Plan encourages members, providers and employees to report all cases of fraud, waste and abuse. If you know of any Medicaid members or providers, including doctors, hospitals and pharmacies, who have committed actions of fraud, waste or abuse, you can report them using the process described below. You may report them anonymously if you choose.

**To Report Potential Fraud, Waste and Abuse:**
You must report any members, providers or pharmacies who have committed fraud, waste or abuse. **You do not have to give your name to report fraud, waste or abuse.**

You can report by calling or writing:

Meridian Health Plan  
Attention: Compliance Officer  
666 Grand Avenue, 14th Floor  
Des Moines, IA 50309  
877-204-9086

You can also report this to the state:

Medicaid Fraud Control Unit of Iowa  
Department of Inspections and Appeals  
312 East 12th Street  
3rd Floor, Lucas State Office Building  
Des Moines, IA 50319  
515-281-5714 (phone)  
515-242-6863 (fax)

You can report anonymously if you choose.

**The False Claims Act**
The False Claims Act is aimed at establishing a law enforcement partnership between federal law enforcement officials and private citizens who learn of fraud against the Government. Under the False Claims Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for up to three times the government’s damages plus civil monetary penalties. The False Claims Act explicitly excludes tax fraud. The Act permits a person with knowledge of fraud against the United States Government to file a lawsuit on behalf of the Government against the person or business that committed the fraud. The lawsuit is known as a “qui tam” case, but it is more commonly referred to as a “whistleblower” case. If the lawsuit is successful, the qui tam plaintiff is rewarded with a percentage of the recovery, typically between 15 and 25%. Any person who files a qui tam lawsuit in good faith is protected by law from any threats, harassment, abuse, intimidation or coercion by his or her employer.

For more information on the False Claims Act, please contact the Meridian Compliance Officer at **877-204-9132.**
Meridian Health Plan offers two Medicare products in Iowa.

**Medicare (D-SNP):**

**Meridian Advantage Plan of Iowa (HMO SNP)** is a Medicare Advantage Prescription Drug Dual Special Needs Plan (MAPD-SNP) for people who have both Medicare and Medicaid. This plan provides members with Part A, Part B and Part D prescription drug benefits and includes additional benefits not covered by Original Medicare.

**Meridian Prime:**

**Meridian Prime (HMO)** is a Medicare Advantage Prescription Drug Plan (MAPD) that provides Part A, Part B and Part D prescription drug benefits and include additional benefits not covered by Original Medicare.

Meridian Advantage Plan of Iowa and Meridian Prime are approved to serve the following counties:
Out-of Network Coverage

In most cases, care Medicare members receive from an out-of-network provider will not be covered. However, there are two exceptions:

- The plan covers emergency care or urgently needed care received from an out-of-network provider. Suppose a member temporarily visits outside the service area, but is still in the United States and has an urgent need for care. The member may not be able to find or get to an in-network provider. In this situation, Meridian covers urgently needed care received from any provider. Meridian does not cover urgently needed care or any other care received outside of the United States.

- If a member needs medical care that Medicare requires Meridian to cover and the providers in our network cannot provide this care, the member can get this care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care from an out-of-network provider.

Meridian has a Continuity of Care policy that allows members continued access to non-contracted practitioners in the following situations:

1. Discontinuation of a contract between Meridian and a practitioner or facility
2. New member in an "active course of treatment" with a non-contracted practitioner at the time of enrollment
3. New member in the second or third trimester of pregnancy or up to 60 days postpartum at time of enrollment

Meridian staff will arrange for continuation of care for up to 90 days for certain medical issues or for pregnant members for the duration of the pregnancy and up to 60 days postpartum. The lack of a contract with the physician of a newly enrolled member or discontinued contracts between Meridian and a provider will not interfere with this option. Meridian will work with the member and non-network provider to transition care to a provider within the Meridian network during this continuity of care time period. Continuity of care will be administered within all applicable benefit limits.

Exceptions to Continuity of Care policy:

1. Meridian staff may extend the 90 day period as long as necessary to meet unusual member needs
2. Meridian will not approve continued care by a non-participating provider if:
   - The member only requires monitoring of a chronic condition
   - The discontinued contract is based on a professional review action for provider incompetence or inappropriate conduct and the welfare of the member would be in jeopardy
   - The provider is unwilling to continue care of the member
   - Care with the non-participating provider was initiated after the member was enrolled with Meridian
   - The provider who would do the ongoing care either did not meet our credentialing policies/criteria in the past or attempts to become credentialed while providing ongoing care and does not meet the credentialing policies/criteria
D-SNP Claims Payment
Meridian does not coordinate payments for the Medicaid and Medicare portion of a claim for Meridian Advantage Plan of Iowa members. Meridian only covers the Medicare portion of the claim. Providers need to bill the Iowa Medicaid Enterprise for the Medicaid portion.

Medicare Benefits Grid

<table>
<thead>
<tr>
<th></th>
<th>Meridian Advantage Plan of Iowa</th>
<th>Meridian Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium and MOOP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthley Premium¹</td>
<td>$0*</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum</td>
<td>$6,700*</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Inpatient Care²</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital (Acute)</td>
<td>$0 copay*</td>
<td>$200 copay for days 1-5</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>$0 copay*</td>
<td>$0 for days 1-20; $150 for days 21-100</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>$0 copay*</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Outpatient Care³</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider (PCP)</td>
<td>$0 copay*</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Emergency Care⁴</td>
<td>$0 copay*</td>
<td>$65 copay</td>
</tr>
<tr>
<td>Ambulance</td>
<td>$0 copay*</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Urgently Needed Care</td>
<td>$0 copay*</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Substance Abuse</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Surgery-Ambulatory Surgical Center</td>
<td>$0 copay*</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Outpatient Surgery-Hospital</td>
<td>$0 copay*</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Outpatient Rehabilitation (PT/OT/ST)</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient Observation</td>
<td>$0 copay*</td>
<td>$150 copay</td>
</tr>
<tr>
<td>Chiropractic (Medicare Covered)</td>
<td>$0 copay*</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Podiatry (Medicare Covered)</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td><strong>Outpatient Medical Services and Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$0 copay*</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>$0 copay*</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Diabetes Programs and Supplies</td>
<td>$0 copay*</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Radiology</td>
<td>$0 copay*</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Radiology Services General/Therapeutic</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Radiology Complex (MRI/CT Scan)</td>
<td>$0 copay*</td>
<td>$65 copay</td>
</tr>
<tr>
<td>Lab Services</td>
<td>$0 copay*</td>
<td>$25 copay</td>
</tr>
</tbody>
</table>

Revised: July 8, 2015
## Meridian Advantage Plan of Iowa

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Meridian Advantage Plan of Iowa</th>
<th>Meridian Prime</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone Mass Measurement</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Mammogram</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Flu Immunization</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Pap/Pelvic Screening</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Prostate Screening</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Personalized Prevention Plan Services</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

### Additional Benefits

<table>
<thead>
<tr>
<th>Preventive Dental Services</th>
<th>N/A</th>
<th>$0 copay/$500 annually for one exam and cleaning every 6 months; one x-ray and fluoride treatment every 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Dental Services</td>
<td>N/A</td>
<td>$0 copay/$150 annually for one exam and cleaning every 6 months; one x-ray and fluoride treatment every 12 months</td>
</tr>
<tr>
<td>Hearing Exams (Medicare Covered)</td>
<td>$0 copay*</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Hearing Exams (Routine)</td>
<td>$0 copay</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Eyeglasses/Contact Lenses</td>
<td>$0 copay/$229 annually</td>
<td>$0 copay/$100 annually</td>
</tr>
<tr>
<td>Non-Emergency Transportation</td>
<td>10 round trips</td>
<td>N/A</td>
</tr>
<tr>
<td>Over-the-Counter Items&lt;sup&gt;5&lt;/sup&gt;</td>
<td>$25/monthly</td>
<td>$20/monthly</td>
</tr>
<tr>
<td>Worldwide Coverage</td>
<td>N/A</td>
<td>$10,000/annually</td>
</tr>
</tbody>
</table>

*Premiums, copays, coinsurances and deductibles vary based on the level of Extra Help received*

<sup>1</sup> Members must continue to pay their Medicare Part B premium. The Part B premium is covered for full-dual eligible individuals

<sup>2</sup> Except for emergency situation, providers must inform Meridian if a member is going to be admitted to a hospital

<sup>3</sup> Members must receive services except in the case of emergency or urgently needed care situations. If members obtain routine care from outside of our network providers, neither the plan nor Medicare will be responsible for the costs

<sup>4</sup> Copay waived for emergency care if admitted to the hospital within three days for the same condition

<sup>5</sup> Members must select items from plan OTC catalog. Items purchase at a retail location will not be reimbursed

<sup>6</sup> Members must use network pharmacies for prescription benefits, except under non-routine circumstances. Limitations and restrictions may apply

The general Meridian policies and procedures are applicable to both Medicaid and Medicare members. For more information on our Medicare products, visit www.medicaremeridian.com.
Utilization Management  Phone: 877-204-9072  Fax: 515-802-3560

- Process referrals
- Perform corporate pre-service review of select services
- Collect supporting clinical information for select services
- Conduct inpatient review and discharge planning activities
- Coordinate Care Coordination services

Member Services  Phone: 877-204-9132  Fax: 515-802-3566

- Verify member eligibility
- Obtain member schedule of benefits
- Obtain general information and assistance
- Determine claims status
- Encounter inquiry
- Record member personal data change
- Obtain member benefit interpretation
- File complaints and grievances
- Verify / record newborn coverage
- Coordination of Benefit questions

Provider Services  Phone: 877-204-8977  Fax: 515-802-3638

- Fee schedule assistance
- Discuss recurring problems and concerns
- Contractual issues
- Provider education assistance
- Primary care administration
- Initiate physician affiliation, disaffiliation & transfer

Quality Management  Phone: 515-802-3500  Fax: 515-802-3563

- Requests and questions about Clinical Practice Guidelines
- Requests and questions about Preventive Healthcare Guidelines
- Questions about Quality Initiatives
- Questions about QI Regulatory requirements
- Questions about Disease Management Programs

Other Important Phone and Fax Numbers

Main Phone  515-802-3500  Main Fax  515-802-3572
Claims Phone  800-203-8206  Claims Fax  515-802-3570
Magellan Behavioral Health  800-638-8820