ambetter. FROM

2015 Member Handbook

Get to know your plan:

Covered Services

Pharmacy Benefits

Emergency Services

Wellness Programs

For more information, visit

Ambetter.BuckeyeHealthPlan.com

FROM

Thank you for choosing Ambetter from Buckeye Health Plan!

There's nothing more important than your health. And now, it's time for you to take charge of it. As a member of Ambetter from Buckeye Health Plan, there are lots of opportunities to get involved in your care. This member handbook will help you understand all of them.

For other details about your plan's benefits, programs and coverage, log in to your secure online member account at Ambetter.BuckeyeHealthPlan.com and check out your ***Schedule of Benefits.***

YOUR HEALTH IS OUR PRIORITY.

And if you have questions, we're always ready to help.
Get in touch with us:

Member Services:
1-877-687-1189 (TDD/TTY: 1-877-941-9236)

Ambetter.BuckeyeHealthPlan.com

To help you get started, here are a few important highlights.

Create your online Ambetter member account. This secure account will give you access to all of your plan's most important information. [Page 8]

Take advantage of our my health pays™ program and earn reward dollars just for making healthy choices! [Page 34]

Choose your Primary Care Provider (PCP). Our select provider network is designed just for you. Make sure to use in-network providers for all of your healthcare needs. Remember, when a provider is in-network, it means that he/she accepts Ambetter. [Page 17]

Call our free 24/7 Nurse Advice Line if you have a question about your health. This helpful resource provides trustworthy feedback from registered nurses — from the comfort of your own home. [Page 10]

Keep up with your preventive care services, like your well-visits, flu shots and more. Preventive care can keep you from getting sick, which cuts back on time, money and worry! Your preventive care is always 100% covered when you use an in-network provider. [Page 25]

Take charge of your health with our health management programs. To help you lead a healthier life, we offer specialized care for chronic conditions like asthma, diabetes, depression and more. [Page 27]

FROM

Table of Contents

Ambetter | From Buckeye Health Plan 6
How to Contact Us 6
Interpreter Services 7

How Your Plan Works 8
What to Do Now That You're Enrolled 8
Payment Information 9
Member Services 10
24/7 Nurse Advice Line 10

Membership and Coverage Information 11
Paying Your Premium and Grace Period 11
Your *Provider Directory* 12
Your Member Welcome Packet and ID Card 13
Important Ambetter Member ID Card Notes 13
Website Information 14

Covered Services (Medical Service Expense Benefits) 15
Primary Care Provider (PCP) 16
Choosing Your PCP 17
Appointments 17
After-Hours Appointments with Your PCP 18
Changing Your PCP 18
What to Do if Your Provider Leaves the Ambetter Network 19
Urgent Care 20
Emergency Care 21
When to Go to the Emergency Room 22
When NOT to Go to the Emergency Room 22
How to Get Medical Care When You Are Out of the Service Area 23
Providers Not Participating in Our Network 23
Referrals 24
PCP Coordination of Care to Specialists 24
Preventive Care Benefits 25

Health Management 27
Care Management 27
Disease Management Programs 27
Family Planning Services 28
When You Are Pregnant 28
Start Smart for Your Baby® 28

Table of Contents

Behavioral Health Services ... 29
Mental Health and Substance Use Disorder Services ... 29

Pharmacy Benefits ... 30
Pharmacy Program ... 30
Preferred Drug List ... 30
Over-the-Counter Medications and Items ... 31
Filling a Prescription ... 31

Adult Dental Benefits ... 32

Vision Benefits ... 33
Routine Vision ... 33

Ambetter Wellness Programs ... 34
Ambetter's My Health Pays™ Program ... 34
Ambetter's Gym Reimbursement Program ... 34

Utilization Management ... 35
Prior Authorization for Services ... 35
Utilization Review ... 35
Prospective Utilization Review ... 35
Concurrent Utilization Review ... 35
Retrospective Utilization Review ... 36
Service Reconsideration ... 36
Adverse Determination Notices ... 36
Review Criteria ... 37

Member Inquiry, Appeals and Grievances ... 38

Fraud, Waste and Abuse Program ... 48

Member Rights ... 49
Your Privacy ... 51
What Are Your Rights? ... 52
Using Your Rights ... 54

Member Responsibilities ... 55

Ambetter | From Buckeye Health Plan

This member handbook contains an overview of your healthcare benefits and is designed to make it easy for you to understand your new health plan benefits and services. Your specific *Schedule of Benefits* will give you more details on the cost sharing for your covered benefits.

Ambetter from Buckeye Health Plan (Ambetter) combines the strength of a national company with a local provider network of hospitals, primary care physicians and specialty physicians to ensure you receive the highest quality of care. You may also visit our website at Ambetter.BuckeyeHealthPlan.com for more information about our company and our services.

How to Contact Us

Ambetter from Buckeye Health Plan
4349 Easton Way, Suite 200
Columbus, OH 43219

Normal business hours of operation are 8:00 a.m.–5:00 p.m. EST.

Member Services	1-877-687-1189
TTY Line	1-877-941-9236
Fax	1-877-941-8076
State Relay Services	711
Make a Payment	1-877-687-1189
Mental Health/ Substance Use Disorders	1-877-687-1189
24/7 Nurse Advice Line	1-877-687-1189
Emergency	911
Complaints and Grievances	1-877-687-1189
Website	Ambetter.BuckeyeHealthPlan.com

Call Member Services at 1-877-687-1189 to receive a copy of this handbook or your Evidence of Coverage *at no charge to you. If there are any major changes to your* Evidence of Coverage, *we will let you know by mailing new information and posting the latest edition on our website, Ambetter.BuckeyeHealthPlan.com.*

See your Schedule of Benefits *to find out what you will have to pay for your healthcare services or prescriptions. You may also find your* Schedule of Benefits *on our website at Ambetter.BuckeyeHealthPlan.com.*

Please have the following items ready when you call:
- *ID card*
- *Claim number or invoice for billing questions*

Interpreter Services

Ambetter has a free service to help our members who speak languages other than English. This service is very important because you and your doctor must be able to talk about your medical or behavioral health concerns in a way you both can understand.

Our interpreter services are provided to you at no cost. We have representatives that speak Spanish, but can also provide medical interpreters for other languages, including sign language. Ambetter members who are blind or visually impaired and need help with interpretation, can call Member Services for oral interpretation.

To arrange interpretation services, call Member Services at 1-877-687-1189 (TDD/TTY 1-877-941-9236).

What to Do Now That You're Enrolled

1. **Create your online secure member account.** Your member account provides you access to all of your plan benefit and coverage information, such as your member handbook, *Summary of Benefits* and Coverage and claims information, all in one place. To create your account, visit the "For Members" page on Ambetter.BuckeyeHealthPlan.com.

2. **Complete your online Ambetter Welcome Survey.** Completing the survey will help us design your plan around your specific needs. When you complete your survey, you can earn $50 on your My Health Pays™ prepaid Visa® rewards card. To complete your survey, log in to your online member account.

3. **Enroll in automatic bill pay.** Sign up and your monthly premium payment will be automatically withdrawn from your bank account every month. Automatic bill pay is helpful, convenient and secure. To sign up, call Member Services or log in to your online member account.

4. **Pick your Primary Care Provider (PCP).** Your PCP is the main doctor you will see for most of your medical care. This includes your checkups, sick visits and other basic health needs. To pick your PCP, log in to your online member account to see a list of Ambetter providers in your area.

5. **Schedule your annual wellness exam.** See your PCP each year for an annual exam. After your first checkup, you'll get $50 on your My Health Pays™ prepaid Visa® rewards card. And anytime you need care, call your PCP and make an appointment.

Payment Information

How can I pay?

Pay Online: Create your online member account on Ambetter.BuckeyeHealthPlan.com and make payments online. You may also set up automatic bill pay using your prepaid debit card, bank debit card or bank account.

Pay by Phone: Pay over the phone by calling billing services at 1-877-687-1189 between 8 a.m. and 5 p.m. EST. You will have the option to pay using the Interactive Voice Response (IVR) system or by speaking to a billing services representative.

Pay by Mail: Payment can be mailed to the address listed on the billing invoice payment coupon. It is very important that you provide payment by the due date. If your premium payment is not received by this date, Ambetter may not pay providers for your medical and prescription claims.

What are my payment options?

Check or money order: Please detach the payment coupon from the billing invoice and mail it with your check or money order to the address on the coupon. Please remember to write your member ID on the check or money order.

Debit cards: To pay by prepaid debit or bank debit card:

- Follow the "pay online" instructions at Ambetter.BuckeyeHealthPlan.com.
- Pay over the phone by calling 1-877-687-1189 between 8 a.m. and 5 p.m. EST.
- Fill out the payment coupon with your debit card information and mail it to the address on the coupon.

Automatic Bill Pay: Automatic bill pay can be set up by logging in to the secure member portal at Ambetter.BuckeyeHealthPlan.com or by calling billing services at 1-877-687-1189 between 8 a.m. and 5 p.m. EST.

What happens if I pay late?

Premium payments are due in advance, on a calendar month basis. Monthly payments are due before the first day of each month for coverage effective during that month. This means that if any required premium is not paid before the date it is due, the policy will be subject to a grace period. Refer to your member handbook for details on the grace period that applies to you. During the grace period the policy will stay in force, however, claims may pend for covered services provided to the member during the grace period. We will notify the member, as well as providers of the non-payment of premiums and the possibility of denied claims when the member is in the grace period.

If you are terminated for not paying your premium, you are not eligible to enroll with Ambetter again until open enrollment or a special enrollment period.

You can find more information regarding Ambetter's service area and participating providers on our website at Ambetter.BuckeyeHealthPlan.com. For persons with total or partial hearing loss, please call TTY 1-877-941-9236 or visit Ambetter.BuckeyeHealthPlan.com.

How Your Plan Works

Member Services

Our member Services department is available Monday through Friday from 8 a.m. to 5 p.m. EST. Our Member Services department can help you understand how Ambetter works, how to get the care you need, and any other questions you might have about health insurance. Calls received after business hours are routed to our 24/7/365, including holidays, team. **Our Member Services staff can help you with the following:**

- Understanding why it is important to have a primary care provider and helping you find one that meets your needs
- Understanding what's covered by your health plan and what's not covered
- Getting more information about our care management and other helpful programs
- Assisting you with finding other health care providers, like a participating pharmacy or lab
- Requesting a new member ID card or other member materials

24/7 Nurse Advice Line

With our Nurse Advice Line, free clinical help is available right from your home or anywhere you have telephone access, 24 hours a day, 7 days a week, 365 days a year. By having a registered nurse right at your fingertips, you can relax and get the care you need at the moment you need it. Our 24-hour Ambetter Nurse Advice Line provides real-time answers to your health-related questions like the ones below, simply by calling 1-877-687-1189.

- Should I go to the emergency room or my PCP?
- Do you have a health information library I can use?
- I have a question about my health.
- I have a question about my medication.
- I need advice about a sick child.

You should call our 24/7 Nurse Advice Line at any time when you have questions about your healthcare, such as the following:

- Concerns or questions about a chronic condition
- Worries about a condition in the middle of the night
- Advice about when to go to the emergency room

Sometimes you may not be sure if you need to go to the emergency room. Call our Nurse Advice Line. They can help you decide where to go for care.

Membership and Coverage Information

Your enrollment with Ambetter is good for as long as you continue to meet the eligibility requirements of the Health Insurance Marketplace (HIM). You must also pay your monthly premium to Ambetter from Buckeye Health Plan for your coverage to be active. If you are eligible for Advance Premium Tax Credits (APTCs) from the federal government to assist with your monthly premium payments, those payments are paid directly to your health plan; however, you are responsible for any remaining portion.

Ambetter will accept you into our plan upon enrollment in the Health Insurance Marketplace (HIM) regardless of your income, health history, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a member, pre-existing conditions, and/or expected health or genetic status.

To inquire about our Ambetter Health Insurance Marketplace plan, enrollment options and specific plan benefits, visit Ambetter.BuckeyeHealthPlan.com.

Paying Your Premium and Grace Period

If you are receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective. A grace period of three (3) months from the premium due date is given for the payment of premium. Coverage will remain in force during the grace period. If full payment of the premium is not received within the grace period, coverage will be terminated as of the last day of the first month during the grace period, if advance premium tax credits are received.

We will continue to pay all appropriate claims for covered services rendered to you during the first month of the grace period, and may pend claims for covered services rendered to you in the second and third month of the grace period. We will notify the U.S. Department of Health and Human Services (HHS) of the non-payment of premiums. You and your healthcare providers will also be notified of the possibility of denied claims when your coverage is in the second and third month of the grace period. You are not eligible to re-enroll once terminated, unless you have a special enrollment circumstance, such as a marriage or birth in the family, or during annual open enrollment periods.

Grace Period, continued:

If you are not receiving a premium subsidy:

Premium payments are due in advance, on a calendar month basis. Monthly payments are due on or before the first day of each month for coverage effective. There is a one (1) month grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the contract will stay in force; however, claims may pend for covered services rendered to you during the grace period. We will notify the U.S. Department of Health and Human Services (HHS), as necessary, of the non-payment of premiums. You and your healthcare providers will also be notified of the possibility of denied claims when your coverage is in the grace period.

Your Provider Directory

A listing of Ambetter doctors, also known as providers, is available online at Ambetter.BuckeyeHealthPlan.com. Ambetter includes physicians, hospitals, and other healthcare providers who have agreed to provide you with your healthcare services. You may search for providers by using the “Find a Provider” tool on our website and selecting the Ambetter from Buckeye Health Plan network. You can use the ”Find a Provider” tool to help you locate a primary care provider (PCP), a participating pharmacy or laboratory, among other providers. You can narrow your search by:

- Provider specialty
- Zip code
- Gender
- Whether or not they are currently accepting new patients
- Languages spoken.
- Provider qualifications (education, certifications)

At any time, you can request a copy of the **Provider Directory** ***at no charge by calling Member Services at 1-877-687-1189 (TTY 1-877-941-9236). Please note: The website will have the most up-to-date information about our provider network.***

Membership and Coverage Information

Your Member Welcome Packet and ID Card

When you enroll with Ambetter, you receive a member welcome packet. The welcome packet includes basic information about the health plan you selected and member ID cards for you and anyone else on your plan. You will receive your welcome packet and member ID card(s) before your Ambetter health insurance coverage begins.

Important Ambetter Member ID Card Notes

- Please present this card any time you receive healthcare services. This card is proof that you are a member of Ambetter from Buckeye Health Plan.
- You need to keep this card with you at all times.
- If you do not get your Ambetter member ID card before your coverage begins, please call Member Services at 1-877-687-1189 (TDD/TTY 1-877-941-9236). We will send you another card.

Sample Ambetter member ID card
Below is an example of what the Ambetter member ID card typically looks like. Please show this card and your driver's license, or other picture identification, every time you seek any service under your Ambetter health plan.

ambetter. FROM buckeye health plan

IN NETWORK COVERAGE ONLY

SAMPLE

Subscriber: Jane Doe
Member: John Doe
ID #: UXXXXXXXXX
Plan: [illegible]

Rx BIN#: 008019

Copays
PCP:
Specialist:
ER:

Coinsurance (Med/Rx):
Deductible (Med/Rx):
Rx (Generic/Brand):

Front

Ambetter.BuckeyeHealthPlan.com

Member/Provider Services:
1-877-687-1189
TDD/TTY: 1-877-941-9236
24/7 Nurse Line: 1-877-687-1189

Numbers below for providers:
Pharmacy Help Desk: [illegible]
EDI Payor ID: [illegible]
EDI Help Desk: [illegible] ext. 25525

Medical Claims:
Buckeye Health Plan
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

SAMPLE

Additional information can be found in your Evidence of Coverage. If you have an emergency, call 911 or go to the nearest emergency room (ER). Emergency services by a provider not in the plan's network will be covered without prior authorization. For updated coverage information, visit **Ambetter.BuckeyeHealthPlan.com**.

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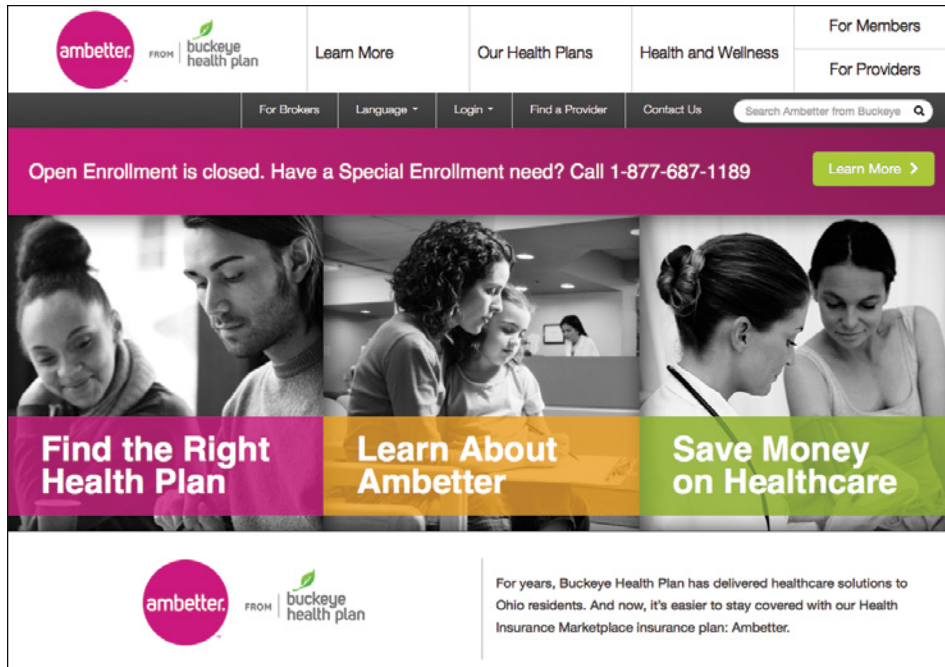
Back

Membership and Coverage Information

Website Information

Ambetter from Buckeye Health Plan's Website:
Ambetter.BuckeyeHealthPlan.com



Ambetter's website helps you get the answers when it's convenient for you, so you can get the right care.

On our website, you are able to:

- Find a primary care provider (PCP)
- Locate other providers, like a pharmacy
- Learn about our programs and services
- Find health information and learn about programs that help you get and stay healthy
- Use your online member account to see:
  - Your claims status (healthcare bills) and premium payment information
  - Your member materials (this handbook, your *Evidence of Coverage* and *Schedule of Benefits*)

When searching for a primary care provider, remember to select an in-network provider. An in-network provider is a provider that accepts Ambetter. Your services may not be covered if you go to an out-of-network doctor.

Covered Services (Medical Service Expense Benefits)

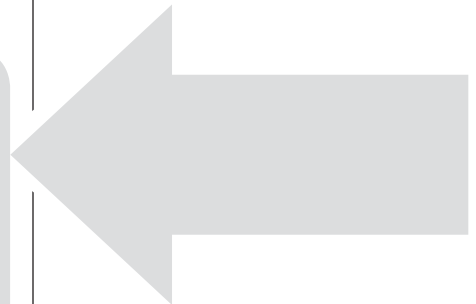
Ambetter provides coverage for a broad range of medically necessary medical and behavioral health services to meet your healthcare needs. For a service to be covered and eligible for reimbursement, the service must be described in this section, prescribed by your treating provider or primary care provider (PCP), and authorized by Ambetter when prior authorization is required.

Please refer to your plan *Schedule of Benefits* for applicable co-payments, co-insurance, and/or deductible. A list of exclusions can be found in your *Evidence of Coverage* document. Certain services require your provider to get authorization prior to the rendering or delivery of the service. These include but are not limited to: services or visits to a non-participating provider, certain surgical procedures and inpatient admissions. If you would like to obtain or verify the status of a service needing authorization, contact Ambetter Member Services at 1-877-687-1189 (TTY 1-877-941-9236). Additional information regarding authorizations can be found in the Prior Authorization section of this handbook.

Prior authorization means receiving approvals to get a service before you visit a doctor, specialist or other provider.

Your Ambetter plan provides the following coverage:

- Visits to your PCP
- Visits to specialists (prior authorization may be needed)
- Hospital inpatient services
- Hospital outpatient services
- Mental health and substance use disorder services
- Pharmacy services
- Maternity benefits and services
- Preventive healthcare services
- Pediatric routine vision services
- Emergency ambulance transportation
- Emergency services
- Urgent care services (in-network)



Your Ambetter plan may also include:
(Please see your *Schedule of Benefits* for more information)

- Routine adult vision services (preventive eye exams, glasses and/or contact lenses).
- Adult dental preventive and basic services.
- Three (3) free visits as a part of your benefits. A free visit includes only the actual visit code provided by your PCP. Any labs, radiology (X-rays), minor surgeries or other services provided during the visit will be subject to your deductible and co-insurance. Please note that preventive care visits, such as an annual well-visit exam, are not included as part of the free visits. Preventive care visits are covered 100 percent by Ambetter.

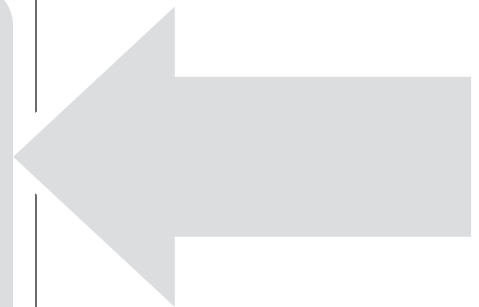
Ambetter covers in-network services only, with the exception of emergency services. If you go to an out-of-network provider without prior approval, you will be responsible for all costs associated with those services. Ambetter has a select, in-network group of providers. We ensure that our contracted providers are skilled and licensed in order to provide the best care to you.

Primary Care Provider

A primary care provider (PCP), also known as your personal doctor, is the doctor that manages all aspects of your healthcare and is the primary person to contact with your health questions and concerns. Ambetter believes that seeing your PCP is important. When you enroll with Ambetter you must choose a PCP. You will need to see your PCP on a regular basis to take care of your basic medical needs. You can call your PCP when you are sick and do not know what to do to feel better. As soon as you join Ambetter, you should contact your PCP. If you have never been to your PCP, you should introduce yourself as a new member, and make an appointment for a preventive visit. It is best to not wait until you are sick to meet your doctor for the first time. Seeing your PCP for regular check-ups helps you find problems early.

Your PCP will:

- Ensure service is timely
- Work with other doctors when you receive care elsewhere
- Coordinate specialty care with Ambetter
- Provide any ongoing care you need
- Update your medical record, which includes keeping track of all the care that you get from all providers
- Treat all patients the same way
- Conduct regular physical exams as needed
- Provide preventive care visits
- Give you regular immunizations as needed
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directives are and file directives appropriately in your medical record



Covered Services (Medical Service Expense Benefits)

Choosing Your PCP

The Ambetter *Provider Directory* is available online at Ambetter.BuckeyeHealthPlan.com on the "Find a Provider" page. The *Provider Directory* lists all participating PCPs, along with their addresses, phone numbers and languages (other than English) they may speak.

As a member of Ambetter from Buckeye Health Plan, you have the freedom to choose any participating Ambetter family practice, general practitioner, internal medicine, nurse practitioner, or physician assistant provider for your PCP. Female members may choose a participating obstetrician/gynecologist (OB/GYN) and child members may choose a participating pediatrician as their PCP. Should you receive services from a nurse practitioner, your benefit coverage and co-payment amounts are the same as the coverage and co-payments listed for services provided by other participating providers. Please refer to your specific *Schedule of Benefits* for co-payment information.

Once you have selected a PCP, we recommend that you make an appointment to meet with him/her once your coverage begins. This will give you and your PCP a chance to get to know each other. Your PCP can give you medical care, advice and information about your health. To make an appointment, call your PCP's office. Remember to take your Ambetter member ID card with you every time you see your PCP.

If you want to know more about the PCP you would like to select, please call Member Services at 1-877-687-1189 (TTY 1-877-941-9236).

Appointments

You should be able to get an appointment with your PCP or specialist in a timely manner.

Appointment Time Frame Standards

Appointment Type	Access Standard
• PCP – Routine Visit	21 calendar days
• PCP – Adult Sick Visit	72 hours
• PCP – Pediatric Sick Visit	24 hours
• Specialist	30 calendar days
• Behavioral Health Non-life-threatening Emergency	Within 6 hours
• Behavioral Health Urgent Care	48 hours
• Behavioral Health Routine Office Visit	10 business days
• Urgent Care Providers	24 hours
• Emergency Providers	Immediately - 24 hours a day, 7 days a week and without prior authorization
• Initial Visit – Pregnant Women	14 calendar days

After-Hours Appointments with Your PCP

You can call your PCP's office for information on how to receive care after office hours. If you have an urgent medical problem or question and cannot reach your PCP during normal office hours, you can call our 24/7 Nurse Advice Line, at 1-877-687-1189 (TTY 1-877-941-9236). If you have an emergency, call 911 or go to the nearest emergency room.

Provider Types That May Serve as PCPs

Providers who may serve as PCPs include family practitioners, general practitioners, pediatricians, internists or OB-GYN physicians. In addition, nurse practitioners in one of the preceding specialties may also serve as a PCP.

Changing Your PCP

Ambetter offers its members the freedom of choice in choosing any available PCP in our network. When you joined Ambetter, you may have selected a PCP. If you would like to change your PCP or select a new PCP, visit Ambetter.BuckeyeHealthPlan.com or call Member Services.

If you cannot keep an appointment, please call the provider's office to cancel at least 24 hours in advance. If you need to change an appointment, call the provider's office as soon as possible. They can make a new appointment for you. If you need help getting an appointment, call Member Services at 1-877-687-1189 (TTY 1-877-941-9236).

What to Do if Your Provider Leaves the Ambetter Network

If your PCP is planning to leave the Ambetter provider network, we will send you a notice 30 days before the date a provider intends to leave, or as soon as Ambetter is notified by the provider. Please contact Member Services at 1-877-687-1189 (TTY 1-877-941-9236) as soon as you are aware that your PCP is leaving the Ambetter network so we can help you choose a new PCP. Ambetter will permit you to continue to be covered for health services, consistent with the terms of your EOC, by the PCP for at least 30 days after the PCP has dis-enrolled.

If you are in your second or third trimester of pregnancy when your PCP dis-enrolls, you may continue to see your PCP until you have delivered your baby and completed your first postpartum visit, provided that your PCP's disenrollment from Ambetter is not for quality related reasons or due to fraud. If you are terminally ill, you may continue to see your PCP indefinitely.

If you have been seeing a specialist who dis-enrolls from the Ambetter provider network, please call Member Services at 1-877-687-1189 (TTY 1-877-941-9236) and we will work with you to ensure your care continues. We will assist you in locating another specialist within the Ambetter network.

In order to continue to provide coverage as noted above, the PCP or specialist has to agree to:

- Accept reimbursement from Ambetter at the rates prior to giving disenrollment notice as payment in full, and to not impose co-payments that would exceed your co-payments if the provider had not dis-enrolled
- Adhere to Ambetter quality assurance standards and to providing necessary medical information related to the care
- Adhere to Ambetter's policies and procedures, including procedures regarding referrals, authorization requirements and, as applicable, the provision of services pursuant to a treatment plan approved by Ambetter

Ambetter covers in-network services only, with the exception of emergency services. If you go to an out-of-network provider without prior approval, you will be responsible for all costs associated with those services. Ambetter has a robust, in-network group of providers. We ensure that our contracted providers are skilled and licensed, in order to provide the best care to you.

Except for emergency services, Ambetter does not provide coverage for care delivered by a non-participating provider. In certain situations, prior authorization may be granted for such services if they are requested by your PCP. For more information, please see the Providers Not Participating in Our Network section of this manual.

Urgent Care

Urgent care is not emergency care. Urgent care is needed when you have an injury or illness that must be treated within 48 hours. It is usually not life-threatening; however, you can't wait for a routine doctor's office visit. Only go to the emergency room if your doctor tells you to go, or you have a life-threatening emergency.

When you need urgent care, follow these steps:

1. Call your PCP. Your PCP may give you care and directions over the phone or direct you to the appropriate place for care.
2. If it is after hours and you cannot reach your PCP, call our 24/7 Nurse Advice Line at 1-877-687-1189 (TTY 1-877-941-9236). You will be able to speak to a nurse. Have your Ambetter member ID card number ready. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number so that he/she can call you back if necessary. During normal office hours, the nurse will assist you with contacting your PCP.

If you are told to see another doctor or to go to the nearest hospital emergency room, bring your Ambetter member ID card. Ask the doctor to call your PCP or Ambetter so that they are aware of your emergency room visit. Urgent care is only covered when provided by an in-network provider.

Emergency Care

Ambetter covers emergency medical and behavioral health services 24 hours a day, 7 days a week, when provided in or out of the service area. Emergency services are required to treat an accidental injury or an onset of what reasonably appears to be a medical condition. An emergency arises when the lack of medical attention could be expected by a reasonable layperson to result in jeopardy to a member's health, or in the case of a pregnant woman, the health of her or her unborn child.

Emergency Rooms Are for Emergencies

If you can, call your doctor first. If your condition is severe, call 911 or go to the nearest hospital. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do. If your PCP is not available, an on-call doctor can help. There may be a message telling you what to do.

For emergency care, the hospital does not have to be part of to the Ambetter from Buckeye Health Plan network. You can use any hospital to receive emergency services. However, you or someone acting on your behalf MUST call your PCP and Ambetter within one (1) business day of your admission. This helps your PCP to provide or arrange for any follow-up care that you may need. Depending on your health plan type, co-payments may apply for emergency care received in an emergency room.

You may obtain emergency behavioral health services by either calling the local pre-hospital emergency medical service system or 911. We do not discourage you from using either phone number if you have an emergency. If you have an emergency behavioral health condition that would be judged by a prudent layperson to require pre-hospital emergency services, please call.

You will not be denied coverage for medical and transportation expenses incurred as a result of such an emergency behavioral health condition.

You can also call our 24/7 Nurse Advice Line, our 24-hour medical advice line at 1-877-687-1189 (TTY 1-877 941-9236) if you are not sure if you have an emergency or not.

Covered Services (Medical Service Expense Benefits)

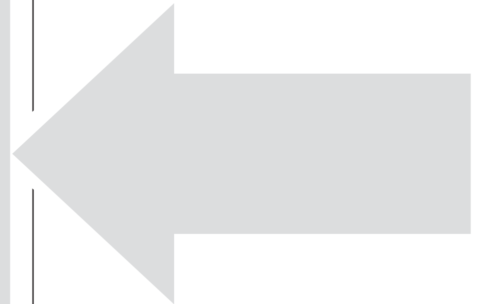
When to Go to the Emergency Room

- Broken bones
- Gun or knife wounds
- Bleeding that will not stop
- You are pregnant, and either in labor or bleeding.
- Severe chest pain or heart attack
- Drug overdose
- Poisoning
- Bad burns
- Shock (you may sweat, feel thirsty or dizzy, or have pale skin)
- Convulsions or seizures
- Trouble breathing
- Suddenly unable to see, move or speak

You can also call our 24/7 Nurse Advice Line at 1-877-687-1189.

When NOT to Go to the Emergency Room

- Flu, colds, sore throats and earaches
- A sprain or strain
- A cut or scrape not requiring stitches
- To get more medicine or have a prescription refilled
- Diaper rash



How to Get Medical Care When You Are Out of the Service Area

If you are temporarily out of the service area and have a medical or behavioral health emergency, call 911 or go to the nearest emergency room. Be sure to call your PCP and Ambetter to report your emergency within one (1) business day. You do not need prior approval for emergency care. Routine or maintenance care is not covered outside the service area, but Ambetter will cover emergency care provided in or outside of the service area.

Providers Not Participating in Our Network

You should always see a provider who is part of the Ambetter from Buckeye Health Plan network. You should always see a provider who is participating with Ambetter. An appointment with a non-participating provider (a doctor not in Ambetter's network) must be approved by Ambetter prior to receiving non-emergency or non-urgent treatment. Your PCP will need to call Ambetter to obtain the authorization for you if he/she determines the referral to be appropriate.

If Ambetter approves your appointment with a non-participating provider, your co-payment and deductible will be the same as if a participating provider provided the service. However, if you fail to get prior authorization from Ambetter for a service, or services, from a non-participating provider, no benefit, coverage or reimbursement will be made by Ambetter. You will be financially responsible for payment of the service(s) from the non-participating provider. Ambetter will notify you when the authorization is approved. For emergency card given by non-participating providers, refer to the Emergency Care section of this handbook.

If you are not sure if a provider is in the Ambetter network, call Member Services at 1-877-687-1189 (TTY 1-877-941-9236).

Covered Services (Medical Service Expense Benefits)

Referrals

You may need to see a certain provider for specific medical issues, conditions, injuries and/or diseases. Talk to your PCP first. Your PCP will refer you to a participating specialist who can diagnose and/or treat your specific issue. Do not go to a specialist without being referred by your PCP.

The specialist will not be able to see you without approval from your PCP. Please note there are some services that you may go directly to a provider for without a referral. A listing of these services is available on our website Ambetter.BuckeyeHealthPlan.com. To ensure that you will not be responsible for payment, always make sure you have a referral from your PCP before you seek care from a specialist.

NOTE: The following are services that may require a referral from your PCP:

- Specialist services, including standing or ongoing referrals to a specific provider
- Diagnostic tests (X-ray and lab)
- High tech imaging (CT scans, MRIs, PET scans, etc.); requires prior authorization from Ambetter
- Scheduled outpatient hospital services
- Planned inpatient admission; requires prior authorization from Ambetter
- Clinic services
- Renal dialysis (kidney disease); requires prior authorization from Ambetter
- Durable Medical Equipment (DME); requires prior authorization from Ambetter
- Home healthcare; requires prior authorization from Ambetter

PCP Coordination of Care to Specialists

When medically necessary care is needed beyond the scope of what your PCP can provide, he/she is encouraged to initiate and coordinate the care members receive from specialist providers. Paper referrals are not required.

Preventive Care Benefits

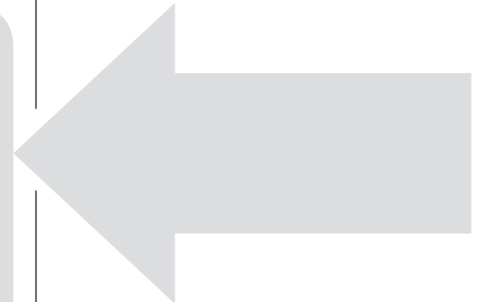
Healthier lifestyle choices inspire healthier lives — and with Ambetter, it's easier for you to play an active role in reaching your best health. That's why we cover certain preventive care services at 100 percent. This way, you can lead a healthy, fulfilling life and stay in charge of your health.

Below is a list of preventive services covered by your Ambetter plan. When you receive these services, be sure to use an in-network provider. An in-network provider is a provider that is participating with the Ambetter from Buckeye Health Plan network. Use our "Find a Provider" tool to find an Ambetter provider.

Services included as part of preventive care are listed below.

For All adults:

- Annual wellness exams
- Blood pressure screenings
- Cholesterol screenings
- Immunizations and vaccines, like the flu vaccine, as recommended by the Centers for Disease Control and Prevention (CDC)



For Women:

- Annual well-woman exams
- Mammography exams
- Pregnancy-related services, such as:
  - RH incompatibility screenings
  - Gestational diabetes screenings
  - Iron deficiency screenings
- Breastfeeding support and supplies

For Infants, Children and Adolescents:

- Well-child visits
- Immunizations and vaccines, as recommended by the Centers for Disease Control and Prevention (CDC)
- Newborn screenings, like a hearing screening and a PKU (Phenylketonuria) screening
- Developmental screening for children under three (3)
- Obesity screening and counseling

Preventive Care Benefits, continued:

Please refer to your *Evidence of Coverage*, located on our website, for a full outline of covered preventive care services. This is located in your online secure member account.

Ambetter covers preventive services that are recommended by the United States Preventive Services Task Force as a Grade A or B, immunizations and vaccines recommended by the Centers for Disease Control and Prevention (CDC), women's preventive care supported by the Health Resources and services Administration (HRSA), and the schedule of wellness visits for infants, children and adolescents recommended by the American Academy of Pediatrics.

Health Management

Ambetter is committed to providing quality healthcare for you and your family. Our primary goal is to provide you with quality healthcare to keep you and your family healthy and help you or a family member with any illness or disability.

Care Management

We understand some members have special needs. Ambetter offers our members with complex medical or behavioral health needs, care management services that are member-centered, family-focused and culturally competent. Our care managers are registered nurses or social workers. They can help you:

- Better understand and manage your health condition
- Coordinate services
- Locate community resources

A care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, the care manager will work with you, your PCP and managing providers to develop a plan of care that meets your needs and the caregiver's needs.

If you feel that you could benefit from care management or health management services, please call Member Services at 1-877-687-1189 (TTY 1-877-941-9236).

Disease Management Programs

Ambetter uses a nationally recognized disease management company, to offer disease management services to members with chronic conditions. This disease management company provides telephonic outreach, education and support to help eligible members learn how to control their condition more effectively, have fewer complications and better understand their condition to live a healthier lifestyle. Ambetter also offers behavioral health services, including depression management programs.

Ambetter offers a Disease Management Program for these conditions:

- Asthma–child and adult
- Coronary Artery Disease (heart disease)–adult only
- Depression
- Diabetes–child and adult
- Hyperlipidemia
- Hypertension (high blood pressure) and high cholesterol
- Low back pain
- Tobacco cessation
- TeleCare Management (TCM)

Quitting smoking is the most important thing you can do for your health. We understand how hard it can be to quit, so we are here to help. Ambetter offers a tobacco cessation program is designed for people who are ready to quit smoking. The program provides you with the support and information you need to quit once and for all.

Family Planning Services

Family planning services are directly related to the prevention of pregnancy. These services include: birth control counseling, education about family planning, examination and treatment, laboratory examinations and tests, medically approved methods and procedures, pharmacy supplies and devices. (Abortion is not considered a family planning service.)

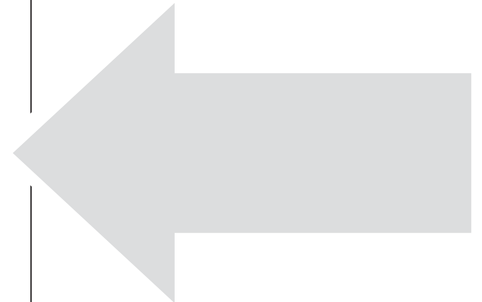
Please call us at 1-877-687-1189 (TTY 1-877-941-9236) as soon as you learn you are pregnant.

When You Are Pregnant

Keep these important points in mind if you are pregnant now or want to become pregnant:

- Go to the doctor as soon as you think you are pregnant. It is important for you and your baby's health to see a doctor as early as possible. Seeing your doctor early will help your baby get off to a good start. It is even better to see your doctor before you get pregnant, so you can prepare for pregnancy.
- Maintain healthy lifestyle habits. These include exercising, eating balanced and healthy meals, and resting for 8-10 hours a night.
- Do not use tobacco, alcohol or drugs now or while you're pregnant.

TIP: Please let us know if you are pregnant. We would like to help you take care of yourself and your baby during your pregnancy. Be sure to visit our website Ambetter.BuckeyeHealthPlan.com to complete a Notification of Pregnancy form.



Start Smart for Your Baby®

Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant. We want to help you take care of yourself and your child throughout the pregnancy and infancy. Information will be given by mail and telephone.

Behavioral Health Services

Mental Health and Substance Use Disorder Services

All mental health and substance use disorder benefits are provided on a non-discriminatory basis to all enrollees for the diagnosis and medically necessary active treatment of mental, emotional and substance use disorders. Deductible, co-payments and treatment limits for behavioral health services will be applied in the same manner as physical health services.

You may choose any provider in Ambetter's behavioral health network. And, you do not need a referral from your PCP.

While medication management visits do not require prior authorization for participating providers, some behavioral health services may require prior authorization. Please refer to your *Evidence of Coverage*, or contact Member Services, for further details.

Pharmacy Benefits

Pharmacy Program

Ambetter provides appropriate, high-quality and cost-effective drug therapy to all Ambetter members. Ambetter works with providers and pharmacists to ensure that medications used to treat a variety of conditions and diseases are covered. Ambetter covers prescription medications and certain over-the-counter medications when ordered by an Ambetter provider. But, the pharmacy program does not cover all medications. Some medications require prior authorization or have limitations for dosage, maximum quantities or age requirements. Please see your *Evidence of Coverage* or call Member Services.

If Ambetter does not grant prior authorization, we will notify you and your provider and provide information regarding the appeal process. Refer to the Member Inquiry, Appeals and Grievances section of this manual for more information. If you want more information about our pharmacy program, visit our website at Ambetter.BuckeyeHealthPlan.com or call us at 1-877-687-1189 (TTY 1-877-941-9236).

Preferred Drug List

The Ambetter Preferred Drug List (PDL) is the list of all drugs Ambetter covers. The PDL applies to drugs you receive at retail pharmacies and our mail-order pharmacy. The Ambetter PDL is continually evaluated by the Ambetter Pharmacy and Therapeutics (P&T) Committee to promote appropriate and cost-effective use of medications. The committee consists of physicians, pharmacists and other healthcare professionals representing local interests and selected with the guidance of the Ambetter medical staff.

For the most current Ambetter Preferred Drug List (PDL) call Member Services at 1-877-687-1189 (TTY 1-877-941-9236) or visit Ambetter.BuckeyeHealthPlan.com.

Over-the-Counter Medications and Items

The Ambetter PDL covers a variety of over-the-counter (OTC) medications. All covered OTCs appear in the Ambetter PDL with an “OTC with Rx” designation. OTC with Rx means that Ambetter PDL OTCs are covered when you have a prescription from a licensed provider that meets all the legal requirements for a prescription.

Filling a Prescription

You can have your prescriptions filled at a participating retail pharmacy or by Ambetter’s mail-order pharmacy.

If you decide to have your prescription filled at a participating retail pharmacy, you can locate a pharmacy near you by using the Ambetter *Provider Directory* available on the Ambetter.BuckeyeHealthPlan.com “Find a Provider” page. You may also call a Member Services Representative to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your Ambetter member ID card.

Ambetter also offers a 90-day supply [three (3) month supply] of maintenance medications by mail for specific benefit plans. These drugs are used to treat long-term conditions or illnesses ,such as high blood pressure, asthma and diabetes. You can find a list of covered medications that can be mailed directly to you on our website at Ambetter.BuckeyeHealthPlan.com.

If you need to transfer a current prescription, or have your doctor phone a prescription, directly to our mail-order pharmacy, call RxDirect at 1-800-785-4197.

Adult Dental Benefits

Ambetter offers an optional adult dental package that can be purchased in addition to your current health plan. The additional dental benefit package provides members with coverage for basic preventive care, such as X-rays and cleanings, and some restorative care, like fillings and extractions.

The dental package can be purchased for a minimal monthly charge. The product does have an annual maximum for the year that applies to all covered services, patient co-payments for certain types of services. There is a six-month waiting period for coverage on restorative care. Members must visit an in-network provider. You will be financially responsible for payment of the service(s) if you see an out-of-network provider.

Please see your *Schedule of Benefits* for your specific monthly premium and co-payment amounts.

Vision Benefits

Routine Vision

Routine eye exams, prescription eyeglasses and contact lenses are covered for all children under age 19, and may be available for adults age 19 and older. For information regarding your specific co-payments and/or deductible, please refer to your specific plan information listed in your *Schedule of Benefits*.

Ambetter Wellness Programs

Ambetter's myhealthpays™ Program

Ambetter encourages members to receive annual preventive services through our unique rewards program.

You can earn rewards for:

- Completing your online Ambetter Welcome Survey
- Your annual wellness exam with your primary care provider
- Your annual flu vaccine

Rewards are automatically put on your My Health Pays™ prepaid Visa® rewards card once they are earned, so there's nothing extra to do! You can then use your reward dollars to help pay for your co-pays, deductibles and monthly premiums. Additional information can be found on our website, Ambetter.BuckeyeHealthPlan.com.

Ambetter's Gym Reimbursement Program

Ambetter promotes healthy lifestyle choices, like using a gym or health club on a regular basis. To help make it more affordable for our members who want to stay healthy and active, Ambetter will reimburse members that regularly use their health club or gym. A portion of your monthly dues will be reimbursed onto your My Health Pays™ prepaid Visa® rewards card. For additional details on this program, visit Ambetter.BuckeyeHealthPlan.com.

Certain fitness programs may also qualify for reimbursement. Check the *Schedule of Benefits* for your particular health plan for the specific amounts that you can get reimbursed. To receive your reimbursement, you must file your claim no later than three (3) months after the benefit year for which you are requesting the benefit.

Utilization Management

Prior Authorization for Services

Prior authorization means pre-approval for services. Prior authorization is necessary for services that must be approved by Ambetter before you get the service. Check with your PCP, the ordering provider or Ambetter Member Services to see if the service requires authorization. When a prior authorization request from your provider is received by Ambetter, it is reviewed by our nurses and doctors. We will let you and your doctor know if the service is approved or denied. Information about the review process, including the time frames for making a decision and notifying you and your provider of the decision, is located in the following Utilization Review section.

You can also visit Ambetter.BuckeyeHealthPlan.com to check authorization and benefit coverage.

Utilization Review

Ambetter has a utilization review program that reviews services to ensure the services you receive are the best way to help improve your health condition. Medical services, medical and surgical supplies, some drugs and other services are reviewed to determine if the services are covered under your plan, medically necessary and are provided in the most clinically appropriate manner. The following methods are used to accomplish this goal.

Prospective Utilization Review

Proposed services are reviewed and approved prior to the service being performed. An initial determination will be made once the health plan has received all necessary information. “Necessary information” includes the results of any face-to-face clinical evaluation (including diagnostic testing) or second opinion that may be required. We will notify you and your provider by written confirmation to let you know if the services have been approved or denied. If your service(s) or benefit(s) is denied, we will include information for filing an internal appeal if you do not agree with the decision.

Concurrent Utilization Review

This process is used to review ongoing services or treatment plans as they are occur and to determine when treatment may no longer be medically necessary. (e.g., the ongoing review of an inpatient stay or admission). This process includes discharge planning to ensure services you need after your discharge is arranged and provided to you.

Retrospective Utilization Review

Ambetter may perform a retrospective review to assure the information provided at the time of authorization was correct and complete, or instances where authorization and/or timely notification was not obtained by Ambetter prior to services being rendered due to extenuating circumstances.

Service Reconsideration

When your provider is first informed that a service has been denied, Ambetter will offer your provider the opportunity to ask for the service to be reconsidered by Ambetter's Medical Director. If the denial is not reversed, you or your authorized representative (including provider) may request an internal appeal. The reconsideration process is not a prerequisite to a grievance or internal appeal.

Adverse Determination Notices

A denial of services based on medical necessity is an adverse determination. An adverse determination is defined as "a determination by Ambetter, based upon a review of information provided, that denies, reduces, modifies or terminates a healthcare service for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting, and level of care or effectiveness."

In the event an adverse determination is made, you will be provided written notification of the determination within the specified time frames listed for a prospective, concurrent or retrospective review. The written adverse determination notification will include detailed information about the reason for the determination, as well as time frames for submitting an internal appeal of the decision.

You are not financially responsible for inpatient services you got prior to receiving an adverse determination notice; however, you may be financially responsible for services you get one calendar day or more past the date you received the adverse determination notice.

Utilization Management

Review Criteria

Criteria are established and periodically evaluated and updated with appropriate involvement from providers who are members of the Ambetter Utilization Management Committee. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case. An Ambetter Medical Director reviews all potential medical necessity denial decisions.

NOTE: Ambetter takes steps to ensure that decisions regarding the provision of healthcare services are based solely on appropriateness of care and services, and the existence of coverage. Ambetter has policies in place to ensure that:

- **Decision making is based only on appropriateness of care and service, and existence of coverage.**
- **The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.**
- **Financial incentives for decision makers do not encourage decisions that result in underutilization; a member or the treating providers may obtain the criteria used to make a specific adverse determination by contacting the medical management department at 1-877-687-1189 (TTY 1-877-941-9236).**

For more information about the review process, including the time frames for making a decision, and notifying you and your provider of the decision, please refer to our website, Ambetter.BuckeyeHealthPlan.com or contact Member Services at 1-877-687-1189 (TTY1-877-941-9236).

Member Inquiry, Appeals and Grievances

If You Need Help

If you do not understand your rights, need assistance understanding your rights or if you do not understand some or all of the information in the following provisions, you may contact Buckeye Health Plan at:

Ambetter from Buckeye Health Plan
Member Services Department
4349 Easton Way, Suite 200
Columbus, OH 43219

Phone: 1-877-687-1189
Fax: 1-877-941-8076

Website: Ambetter.BuckeyeHealthPlan.com

Grievance Process

A grievance or complaint is an expression of dissatisfaction regarding our products or services. You or your designee may submit a grievance verbally or in writing. Depending on the nature of the grievance and whether or not a response is requested, we will respond verbally and/or in writing within 30 business days following receipt of the grievance. Should a member's medical condition necessitate an expedited review, we will respond within seven (7) days.

The response will state the reason for our decision, inform the member of the right to pursue a further review and explain the procedures for initiating such review. Grievances will be considered when measuring the quality and effectiveness of our products and services.

Member Inquiry, Appeals and Grievances

Internal Claims and Appeals Procedures
When a health insurance plan denies a claim for a treatment or service, a claim for plan benefits you have already received (post-service claim denial), or denies your request to authorize treatment or service (pre-service claim denial), you or someone you have authorized to speak on your behalf (an authorized representative), can request an appeal of the plan's decision. If the plan rescinds your coverage or denies your application for coverage, you may also appeal the plan's decision. When the plan receives your appeal, it is required to review its own decision. When the plan makes a claim decision, it is required to notify you of (provide notice of an adverse benefit determination):

- The reasons for the plan's decision
- Your right to file appeal the claim decision
- Your right to request an external review
- The availability of a Consumer Assistance Program at The Ohio Department of Insurance
- If you do not speak English, you may be entitled to receive appeals information in your native language upon request
- When you request an internal appeal, the plan must give you its decision as soon as possible, but no later than:
  - 72 hours after receiving your request when you are appealing the denial of a claim for urgent care (If your appeal concerns urgent care, you may be able to have the internal appeal and external reviews take place at the same time.)
  - 30 days for appeals of denials of non-urgent care you have not yet received
  - 60 days for appeals of denials of services you have already received (post-service denials)
  - No extensions of the maximum time limits are permitted unless you consent

Continuing Coverage
The plan cannot terminate your benefits until all of the appeals have been exhausted. However, if the plan's decision is ultimately upheld, you may be responsible for paying any outstanding claims or reimbursing the plan for claims payments it made during the time of the appeals.

Cost and Minimums for Appeals
There is no cost to you to file an appeal and there is no minimum amount required to be in dispute.

Member Inquiry, Appeals and Grievances

Defined Terms
Any terms appearing in italics are defined at the end of these provisions.

Emergency Medical Services
If the plan denies a claim for an emergency medical service, your appeal will be handled as an urgent appeal. The plan will advise you at the time it denies the claim that you can file an expedited internal appeal. If you have filed for an expedited internal appeal, you may also file for an expedited external review (see "Simultaneous urgent claim, expedited internal review and external review").

Your Rights to File an Appeal of Denial of Health Benefits
You or your authorized representative, such as your health care provider, may file the appeal in writing, either by mail or by facsimile (fax). For an urgent request, you may also file an appeal by telephone.

Ambetter from Buckeye Health Plan
Appeals Unit
4349 Easton Way, Suite 200
Columbus, OH 43219

Phone: 1-877-687-1189
Fax: 1-877-941-8076

Website: Ambetter.BuckeyeHealthPlan.com

Please include in your written appeal or be prepared to tell us the following:

- Name, address and telephone number of the insured person
- The insured's health plan identification number
- Name of healthcare provider, address and telephone number
- Date the healthcare benefit was provided (if a post-claim denial appeal)
- Name, address and telephone number of an authorized representative (if appeal is filed by a person other than the insured)
- A copy of the notice of adverse benefit determination

Rescission of Coverage
If the plan rescinds your coverage, you may file an appeal according to the following procedures. The plan cannot terminate your benefits until all of the appeals have been exhausted. Since a rescission means that no coverage ever existed, if the plan's decision to rescind is upheld, you will be responsible for payment of all claims for your health care services.

Time Limits for Filing an Internal Claim or Appeal
You must file the internal appeal within 180 days of the receipt of the notice of claim denial (an adverse benefit determination). Failure to file within this time limit may result in the company's declining to consider the appeal.

In general, the health plan may unilaterally extend the time for providing a decision on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the plan determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

Time Limits for an External Appeal
You have 180 days to file for an external review after receipt of the plan's final adverse benefit determination.

Your Rights to a Full and Fair Review
The plan must allow you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

- The plan must provide you, free of charge, with any new or additional evidence considered, relied upon or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to give you a reasonable opportunity to respond prior to that date; and
- Before the plan can issue a final, internal, adverse benefit determination based on a new or additional rationale, you must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final, internal, adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date.
- The adverse determination must be written in a manner understood by you or, if applicable, your authorized representative and must include all of the following:
  - The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers)
  - Information sufficient to identify the claim involved, including the date of service and the health care provider
  - A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning
- As a general matter, the plan may deny claims at any point in the administrative process on the basis that it does not have sufficient information. Such a decision, however, will allow you to advance to the next stage of the claims process.

Other Resources to Help You

Department of Insurance
For questions about your rights, or for assistance, you may also contact the Consumer Services Division at The Ohio Department of Insurance (800) 686-1526.

Department of Labor
If this is a health plan provided through your employer or under a retiree health benefit plan through your former employer, your rights are also protected by ERISA. For information about your rights under ERISA, you may contact the **Employee Benefits Security Administration (EBSA)**, an agency of the Department of Labor, at 1-866-444-3272.

Language services are available from the health benefit plan and from The Ohio Department of Insurance.

Your rights to appeal and the instructions for filing an appeal are described in the provisions following this Overview.

INTERNAL CLAIMS AND APPEALS

Non-urgent, Pre-service Claim Denial
For a non-urgent pre-service claim, the plan will notify you of its decision as soon as possible but no later than 15 days after receipt of the claim.

If the plan needs more time, it will contact you, in writing, telling you the reasons why it needs more time and the date when it expects to have a decision for you, which should be no later than 15 days.

If the plan needs additional information from you before it can make its decision, it will provide a notice to you, describing the information needed. You will have 45 days from the date of the plan's notice to provide the information. If you do not provide the additional information, the plan can deny your claim. In which case, you may file an appeal.

The plan must make its decision within 48 hours after receipt of the information or at the end of the 45 days, whichever comes first.

Urgent Pre-service Care Claim Denial

If your claim for benefits is urgent, you or your authorized representative or your health care provider (physician) may contact us with the claim, orally or in writing.

If the claim for benefits is one involving urgent care, we will notify you of our decision as soon as possible, but no later than 72 hours after we receive your claim, provided you have given us information sufficient to make a decision.

If you have not given us sufficient information, we will contact you as soon as possible, but no more than 24 hours after we receive your claim, to let you know the specific information we will need to make a decision. You must give us the specific information requested as soon as you can but no later than 48 hours after we have asked you for the information.

We will notify you of our decision as soon as possible, but no later than 48 hours after we have received the needed information or the end of the 48 hours you had to provide the additional information.

To assure you receive notice of our decision, we will contact you by telephone or facsimile (fax) or by another method meant to provide the decision to you quickly.

In determining whether a claim involves urgent care, the plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a physician with knowledge of your medical condition determines that a claim involves urgent care or an emergency, the claim must be treated as an urgent care claim.

Simultaneous Urgent Claim and Expedited Internal Review
In the case of a claim involving urgent care, you or your authorized representative may also request an expedited internal review. A request for expedited internal review may be submitted orally or in writing by the claimant; and all necessary information, including the plan's benefit determination on review, shall be transmitted between the plan and the claimant by telephone, facsimile or other expeditious method.

If the physician certifies in writing that you have a medical condition where the time frame for completion of an expedited review of an internal appeal involving an adverse benefit determination would seriously jeopardize your life or health or your ability to regain maximum function, you may file a request for an expedited external review to be conducted simultaneously with the expedited internal appeal, pursuant to section 3922.09 of the Revised Code.

Simultaneous Urgent Claim, Expedited Internal Review and External Review
You or your authorized representative may request an expedited external review if both the following apply:

- You have filed a request for an expedited internal review; and
- After a final adverse benefit determination, if either of the following applies:
  - Your treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, if treated after the time frame of a standard external review;
  - The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which you received emergency services, but have not yet been discharged from a facility.

Concurrent Care Decisions

Reduction or Termination of Ongoing Plan of Treatment
If we have approved an ongoing plan or course of treatment that will continue over a period of time or a certain number of treatments, and we notify you that we have decided to reduce or terminate the treatment, we will give you notice of that decision, allowing sufficient time to appeal the determination and to receive a decision from us before any interruption of care occurs.

Request to Extend Ongoing Treatment
If you have received approval for an ongoing treatment and wish to extend the treatment beyond what has already been approved, we will consider your appeal as a request for urgent care. If you request an extension of treatment at least 24 hours before the end of the treatment period, we must notify you soon as possible but no later than 24 hours after receipt of the claim. An appeal of this decision is conducted according to the urgent care appeals procedures.

Concurrent Urgent Care and Extension of Treatment
Under the concurrent care provisions, any request that involves both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved by the plan, must be decided as soon as possible, taking into account the medical urgencies Notification must be provided to the claimant within 24 hours after receipt of the claim, provided the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Non-urgent Request to Extend Course of Treatment or Number of Treatments
If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not involve urgent care, the request may be treated as a new benefit claim and decided within the time frame appropriate to the type of claim, e.g., as a pre-service claim or a post-service claim.

If the request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request must be treated as a claim involving urgent care and decided in accordance with the urgent care claim time frames, e.g., as soon as possible, taking into account the medical emergencies, but not later than 72 hours after receipt.

Post-service Appeal of a Claim Denial (Retrospective)
If your appeal is for a post-service claim denial, we will notify you of our decision as soon as possible but no later than 30 days after we have received your appeal. If we need more time, we will contact you, telling you about the reasons why we need more time and the date when we expect to have a decision for you, which should be no later than 15 days, provided that we determine that such an extension is necessary due to matters beyond our control, and we notify you prior to the expiration of the initial 30 day period. If the reason we need more time to make a decision is because you have not given us necessary information, you will have 45 days from the date we notify you to give us the information. We will describe the information needed to make our decision in the notice we send you. This is also known as a "retrospective review." The plan will notify you of its determination as soon as possible but no later than five (5) days after the benefit determination is made.

The plan will let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed and advising you when a final decision is expected. If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period given by the plan to do so ends, whichever comes first. The plan must get your consent if it wants more time after its first extension. The plan must give you notice that your claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

Member Inquiry, Appeals and Grievances

Submitting a Claim
Contracted providers will submit claims on your behalf. In the event you need to file a claim, the information is provided below.

Initial paper claims may be submitted to:

Ambetter from Buckeye Health Plan
P.O. Box 5010
Farmington, MO 63640-5010

Filing a grievance will not affect your healthcare services. We want to know your concerns so we can improve our services. To file a grievance, call Member Services at 1-877-687-1189 (TDD/TTY 1-877-941-9236). You can also write a letter and mail or fax your grievance to Ambetter from Buckeye Health Plan at 1-877-941-8076. Be sure to include:

- Your first and last name
- Your member ID number
- Your address and telephone number
- Why you are unhappy (with as much specific information as possible)
- Any supporting documentation
- What you would like to have happen (desired outcome)

If you are unhappy with a decision made by Ambetter from Buckeye Health Plan, you may file an appeal. Instructions on how to file an appeal will be included in the letter you receive containing the decision.

Please contact Buckeye Health Plan Member Services at 1-877-687-1189 (TDD/TTY 1-877-941-9236) if you have questions about the appeals process.

Fraud, Waste and Abuse Program

Ambetter is serious about finding and reporting fraud and abuse. Our staff is available to talk to you about this and can be contacted at:

Buckeye Health Plan
Compliance Department
4349 Easton Way, Suite 200
Columbus, OH 43219

Fraud, Waste and Abuse Hotline: 1-866-685-8664

The Fraud, Waste and Abuse Hotline is answered by an independent third party and is available 24 hours a day, seven (7) days a week. Fraud means that a member, provider, or another person is misusing the Ambetter program resources including:

- Loaning, selling or giving your member ID card to someone other than yourself
- Misusing benefits
- Wrongful billing by a provider
- Any action to defraud the program

Your healthcare benefits are given to you based on your eligibility for the program. You must not share your benefits with anyone. Providers must report any misuse of benefits to Ambetter. If you misuse your benefits, you could lose them altogether. Legal action can be taken against you if you misuse your benefits.

Abuse is defined as practices that are inconsistent with sound fiscal, business or medical practices, and result in unnecessary cost to the health plan. This includes billing for services that are not covered or medically necessary or that fail to meet professionally recognized standards for health care. Abuse also includes enrollee and provider practices that result in unnecessary cost to the health plan. In the case of abuse, there is no conspiracy or malicious intent to deceive.

Your safety and well-being are very important to us. If you or your family has any concerns, please call us right away. If you think a provider, member or another person is misusing the program's resources, tell us immediately. We will take action against anyone who does this. Ambetter is serious about finding and reporting fraud, waste and abuse. Call Ambetter's Fraud, Waste and Abuse Hotline at 1-866-685-8664. You do not need to give your name.

Member Rights

Members, legal guardians of members and legally authorized surrogates for members have certain rights and responsibilities. It is important that you know your rights and responsibilities. For the full list of rights and responsibilities, please see your *Evidence of Coverage*.

Information

You have the right to request the following information from your PCP about your health, treatment and any known test results, including:

- The right to view your medical records
- The right to be informed of changes within the Ambetter network
- The right to information about Ambetter and its health plans
- The right to a current list of Ambetter providers
- The right to select your PCP
- The right to talk to your PCP about new uses of technology; you can also ask Ambetter for information on our quality plan, how members use the plan and how we review new technology

Ambetter will protect your oral, written or electronic personal health information across the organization.

Respect and Dignity

- You have the right to receive considerate, respectful care at all times.
- You have the right to receive assistance in a prompt, courteous and responsible manner.
- You have the right to be treated with dignity when receiving care.
- You have the right to be free from harassment by the health plan or the plan's providers if there are any business disagreements between the plan and provider.
- You have the right to select a health plan or switch health plans, within the Health Insurance Marketplace (HIM) guidelines, without any threats or harassment.
- You have the right to privacy.

Member Rights

Access

You have the right to adequate access to qualified health professionals. This includes:

- The right to access treatment or services that is medically necessary regardless of age, race, creed, sex, sexual preference, national origin or religion
- The right to access medically necessary, emergency services 24 hours a day and seven (7) days a week
- The right to seek a second medical opinion from a participating provider at no cost to you
- If you have a disability, you have the right to receive information in a different format in compliance with the Americans with Disabilities Act

Informed Consent

Members, or their legal guardians or representatives, have the right to join in decision making about their healthcare. This includes working on any treatment plans and making care decisions. You, as the member, should know any possible risks or problems related to recovery and the likelihood of success. You shall not receive any treatment without consent freely given by you, or your legally authorized surrogate or decision-maker, and you will be informed of your care options.

You have the right to know who is approving and who is performing the procedures or treatment. All likely treatment, and the nature of the problem should be explained clearly. You have the right to a candid discussion on appropriate clinically or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

Grievances

You have the right to file an appeal or grievance if you have had an unsatisfactory experience with Ambetter or with any of our participating providers, or if you disagree with certain decisions made by Ambetter.

External Review

You have the right to request an independent external review with the Ohio Department of Insurance for appeals or grievances not resolved to your satisfaction by Ambetter.

Rights and Responsibilities Policies

Members have a right to make recommendations regarding the organization's Member Rights and Responsibilities policies.

Your Privacy

At Ambetter, your privacy is important. We have policies in place to protect your health records. Ambetter protects all oral, written and electronic Protected Health Information (PHI) across the organization. We follow Health Insurance Portability and Accountability (HIPAA) requirements and have a Notice of Privacy Practices. We are required to notify you about these practices every year. This notice describes how your medical information may be used and disclosed, and how you can get access to this information. Please review it carefully. If you need more information or would like the complete notice, please visit Ambetter.BuckeyeHealthPlan.com.

Refusal of Treatment

You may refuse treatment to the extent that the law allows. You are responsible for your actions if treatment is refused or if the PCP's instructions are not followed. You should discuss all concerns about treatment with your PCP. Your PCP can discuss different treatment plans with you, and if there is more than one plan that may help you, you or your legal representative will make the final decision.

Identity

You have the right to know the name and job title of people giving you care. You also have the right to know which doctor is your PCP.

Language

You have the right to an interpreter when you do not speak or understand the language being spoken by the provider.

What Are Your Rights?

The following are your rights with regards to your health records. If you would like to exercise any of the following rights, please contact us.

- You have the right to ask us to give your records only to certain people or groups, and to indicate the reasons for doing so. You also have the right to ask us to stop your records from being given to family members or others who are involved in your healthcare. Please note that while we will try to follow your wishes, the law does not require us to do so.
- You have the right to ask to get confidential communications of your health records. For example, if you believe that you would be harmed if we send your records to your current mailing address, you can ask us to send your health records by other means. Other means might be fax or an alternate address.
- You have the right to request behavioral health records. This information can only be provided with the approval of the treating provider responsible for the condition to which the information relates, or another equally qualified behavioral health professional. Ambetter will notify you upon the release of any medical or behavioral health record information to a medical professional designated by you.
- You have the right to view and get a copy of all the records we keep about you in your designated record set. This consists of anything we use to make decisions about your health, including enrollment, payment, claims processing and medical management records.

You do not have the right to get certain types of health records. We may decide not to give you the following:

- Information contained in psychotherapy notes
- Information collected in reasonable anticipation of, or for use in, a court case or another legal proceeding
- Information subject to certain federal laws about biological products and clinical laboratories
- In certain situations, we may not let you get a copy of your health records (You will be informed in writing. You may have the right to have our action reviewed.)

Member Rights

What Are Your Rights, continued:

You have the right to ask us to make changes to wrong or incomplete health records we keep about you. These changes are known as amendments. Any request for an amendment must be in writing. You need to give a reason for your change(s). We will get back to you in writing no later than 30 days after we receive your request. If your health information is not maintained on-site, we will respond no later than 60 days after we receive your request. If we need additional time, we may take up to another 30 days. We will inform you of any delays and the date when we will get back to you.

If we make your changes, we will let you know they were made. We will also give your changes to others who we know have your health records and to other persons you name. If we choose not to make your changes, we will let you know why in writing. You will have a right to submit a letter disagreeing with us. We have a right to answer your letter. You then have the right to ask that your original request for changes, our denial and your second letter disagreeing with us be put with your health records for future disclosures.

You have the right to receive an accounting of disclosures of your health records. By law, we do not have to give you a list of the following:

- Health records given or used for treatment, payment and healthcare operations purposes
- Health records given to you or others with your written approval
- Information that is incidental to a use or disclosure otherwise permitted
- Health records given to persons involved in your care or for other notification purposes
- Health records used for national security or intelligence purposes
- Health records given to prisons, police, FBI and others who enforce laws, or health oversight agencies
- Health records given or used as part of a limited data set for research, public health or healthcare operations purposes

To receive an accounting of disclosures, your request must be in writing. We will act on your request within 60 days. If we need more time, we may take up to another 30 days. Your first list will be free. We will give you one free list every 12 months. If you ask for another list within 12 months, we may charge you a fee. We will tell you the fee in advance and give you a chance to take back your request.

If you have any questions about this notice or how we use or share your health records, please call. We can be reached 1-877-687-1189 (TTY 1-877-941-9236) Monday through Friday from 8:00 a.m. to 5:00 p.m. EST.

Member Rights

Using Your Rights

You have a right to receive a copy of this notice at any time. We reserve the right to change the terms of this notice. Any changes in our privacy practices will apply to all the health records that we keep. If we make changes, we will send a new notice to you.

If you believe your privacy rights have been violated, you may write a letter of complaint to:

Privacy Officer
Buckeye Health Plan
4349 Easton Way, Suite 200
Columbus, OH 43219

Phone: 1-877-687-1189
TDD/TTY: 1-877-941-9236
Fax: 1-877-941-8076

You may also contact the Secretary of the United States Department of Health and Human Services:

Office for Civil Rights - V
U.S. Department of Health and Human Services Government Center
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Phone: 1-800-638-1019
TDD/TTY: 1-800-537-7697
Fax: 1-312-886-1807

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

Contact Ambetter at 1-877-687-1189 (TTY 1-877-941-9236) if you need assistance exercising your rights.

Member Responsibilities

All members are responsible for learning how the Ambetter plan works by reading the *Evidence of Coverage*.

Giving Information
You should give accurate and complete information about present conditions, past illnesses, hospitalizations, medications and other matters about your health to Ambetter and your healthcare providers. You should make it known whether you clearly understand your care and what is expected of you. You need to ask questions of your doctor until you understand the care you are receiving. You need to review and understand the information you receive about Ambetter. You need to know the proper use of services covered by Ambetter.

Your Doctor's Advice and Your Treatment Plan
You should follow the treatment plan suggested by your providers of medical care. You should ask questions to make sure that you fully understand your health problems and treatment plan. You should work with your PCP to develop treatment goals. If you do not follow the treatment plan, you have the right to be advised of the likely results of your decision.

Identification Card (ID Card)
It is important that you show your Ambetter member ID card before you receive care at every appointment.

Emergency Room Use
You should use an emergency room only when you think you have a medical emergency. For all other care, you should call your PCP.

Appointments
You need to keep appointments. If you cannot keep an appointment, you must call to cancel or reschedule. You should schedule appointments during office hours whenever possible.

Primary Care Provider (PCP)
You should know the name of your assigned PCP. You should establish a relationship with your doctor. You may change your PCP verbally or in writing by contacting our Member Services Department at 1-877-687-1189 (TTY 1-877-941-9236).

Treatment
You should treat all Ambetter staff, providers and other members with respect and dignity. Any concerns that you have about your care should be expressed to Ambetter in a useful manner.

Changes
You need to tell Ambetter and the Health Insurance Marketplace about any changes to your address, name or telephone number, or any changes in your family. Call Ambetter at1-877-687-1189 (TTY 1-877-941-9236) or visit the Health Insurance Marketplace.

Member Responsibilities

Other Medical Insurance
When you enroll in Ambetter, you need to give all information about any other medical insurance coverage you have. If, at any time, you get other medical coverage besides your Ambetter coverage, you must tell the Health Insurance Marketplace.

Costs
If you access care without following Ambetter rules, you may be responsible for the charges. If applicable, you are responsible to pay your portion of the monthly premium and all co-payments at the time of service.

Advance Directives
All Ambetter adult members have a right to make advance directives for healthcare decisions. This includes planning treatment before you need it. Advance directives are forms you can complete to protect your rights for medical care. It can help your PCP and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions and will work only when you are unable to speak for yourself.

Examples of advance directives include:

- Living will
- Healthcare power of attorney
- "Do Not Resuscitate" (DNR) orders

You should not be discriminated against for not having an advance directive. For more information regarding advance directives, as well as a form you can use to designate a Healthcare Proxy, please call Member Services at 1-877-687-1189 (TTY 1-877-941-9236) or visit our website, Ambetter.BuckeyeHealthPlan.com.

Notes

Notes:

FROM

Ambetter from Buckeye Health Plan is a Qualified Health Plan Issuer in the Ohio Health Insurance Marketplace. Ambetter from Buckeye Health Plan's policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, write us (4349 Easton Way, Suite 200, Columbus, OH 43219) or call us at 1-877-687-1189 (TTY/TDD 1-877-941-9236).

The phone numbers listed may connect you with a licensed Ambetter agent. AMBETTER™ is a trademark exclusively owned by Centene Corporation, the parent company of Buckeye Health Plan.

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