2017

MEMBER HANDBOOK

Buckeye Health Plan - MyCare Ohio (MMP)

buckeye health plan | MyCareOhio Connecting Medicare + Medicaid

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Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan)

Member Handbook

January 1, 2017 – December 31, 2017

Your Health and Drug Coverage under Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan)

This handbook tells you about your coverage under Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) (Buckeye) through December 31, 2017. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. **This is an important legal document. Please keep it in a safe place.**

This plan, Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan), is offered by Buckeye Community Health Plan, Inc. When this *Member Handbook* says “we,” “us,” or “our,” it means Buckeye Community Health Plan, Inc. When it says “the plan” or “our plan,” it means Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan).

You can get this handbook for free in other languages. Call 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

Usted puede obtener este manual gratuitamente en otros idiomas. Llame a 1-866-549-8289 (TTY: 711) de 8 a. m. a 8 p. m., de lunes a viernes. Luego del horario de atención, los fines de semana y los días feriado, es posible que se le pida que deje un mensaje. Le devolveremos la llamada durante el próximo día hábil. La llamada es gratis.

You can get this handbook for free in other formats, such as large print, braille, or audio. Call 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

If you have any problems reading or understanding this handbook or any other Buckeye information, please contact Member Services. We can explain the information or provide the

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If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

You can ask for materials in other languages and formats, and you can also ask that we send you future materials in this same language or format. To get materials in another language or format, please call Member Services.

Disclaimers

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.

Limitations and restrictions may apply. For more information, call Buckeye Member Services or read the Buckeye Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Buckeye pay for your services.

Chapter 1: Getting started as a member

Table of Contents

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

A. Welcome to Buckeye

Buckeye, offered by Buckeye Community Health Plan, Inc., is a Medicare-Medicaid Plan. A *Medicare-Medicaid plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care managers and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Buckeye was approved by the Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

The MyCare Ohio program is a demonstration program jointly run by ODM and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

B. What are Medicare and Medicaid?

You have both Medicare and Medicaid. Buckeye will make sure these programs work together to get you the care you need.

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Medicare and Ohio Medicaid must approve Buckeye each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, and
- Medicare and Ohio Medicaid approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services would not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medicaid services from Buckeye, including prescription drugs. You do not pay extra to join this health plan.

Buckeye will help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care manager. This is a person who works with you, with Buckeye, and with your care providers to make sure you get the care you need. He or she will be a member of your care team.
- You will be able to direct your own care with help from your care team and care manager.
- The care team and care manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - » Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - » Your care team will make sure your test results are shared with all your doctors and other providers.

D. What is Buckeye's service area?

Buckeye is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

Our service area includes these counties in Ohio: Clark, Cuyahoga, Fulton, Geauga, Greene, Lake, Lorain, Lucas, Medina, Montgomery, Ottawa, and Wood.

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state.

E. What makes you eligible to be a plan member?

You are eligible for membership in our plan as long as:

- you live in our service area; **and**
- you have Medicare Parts A, B, and D; **and**
- you have full Medicaid coverage; **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in Buckeye if you:

- have other third party creditable health care coverage; **or**
- have intellectual or other developmental disabilities and get services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID); **or**
- are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

Additionally, you have the option to not be a member if you:

- are a member of a federally recognized Indian tribe; **or**
- have been determined by the County Board of Developmental Disabilities to qualify for their services.

➔ If you believe that you meet any of the above criteria, please contact Member Services for assistance.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

F. What to expect when you first join a health plan

When you first join the plan, you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. After the assessment, you and your care team will meet and develop your Personal Care Plan.

A care manager from our plan will make a welcome call to you to explain your benefits. They will talk to you about your current health care services and answer any questions you may have about Buckeye. Your care manager may also schedule you for a visit with your PCP if you have not seen them recently for additional information to help complete your assessment. These assessments will be used to help our care team understand your individual health care needs and develop your Personal Care Plan.

You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change. When you join our plan, if you are taking any Medicare Part D prescription drugs that Buckeye does not normally cover, you can get a transition supply. We will also help you get another drug or get an exception for Buckeye to cover your drug, if medically necessary.

If Buckeye is new for you, you can keep seeing the doctors you go to now for at least 90 days after you enroll. Also, if you already had previous approval to get services, our plan will honor the approval until you get the services. This is called a “transition period.” The *New Member Letter* included with your Member Handbook has more information on the transition periods. If you are on the MyCare Ohio Waiver, your Member Handbook Supplement or “Waiver Handbook” also has more information on transition periods for waiver services.

After the transition period, you will need to see doctors and other providers in the Buckeye network for most services. *A network provider is a provider who works with the health plan.* See Chapter 3, Section D, page 29 for more information on getting care. Member Services can help you find a network provider.

If you are currently seeing a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services right away so we can arrange the services and avoid any billing issues.

G. What is a care plan?

A *care plan* is the plan for what health services you will get and how you will get them.

After your health care needs assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Your care team will continuously work with you to update your care plan to address the health services you need and want.

H. Does Buckeye have a monthly plan premium?

No.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, Section 4, page 149. You can also call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048).

The contract is in effect for months in which you are enrolled in Buckeye between January 1, 2017 and December 31, 2017.

J. What other information will you get from us?

You will also get a Buckeye Member ID Card, a *New Member Letter* with important information, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drug*. Members enrolled in a home and community based waiver will also get a

supplement to their Member Handbook that gives information specific to waiver services. If you do not get these items, please call Member Services for assistance.

Your Buckeye Member ID Card

Under the MyCare Ohio program, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions covered by the plan. Here's a sample card to show you what yours will look like:

If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it later.

New Member Letter

Please make sure to read the *New Member Letter* sent with your Member Handbook as it is a quick reference for some important information. For example, it has information on things such as when you may be able to get services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Buckeye network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan (see page 7) and for certain services (see Chapter 3, Section B, page 26).

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

You can ask for a printed *Provider and Pharmacy Directory* at any time by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also see the *Provider and Pharmacy Directory* at http://mmp.buckeyehealthplan.com, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are "network providers"?

- Buckeye's *Network Providers* include:
    - Doctors, nurses, and other health care professionals that you can go to as a member of our plan.
    - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan.
    - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

  For a full list of network providers, see the *Provider and Pharmacy Directory*.
- Network providers have agreed to accept payment from our plan for covered services as payment in full.
- Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, see Chapter 7, Section A, page 110.

What are "network pharmacies"?

- Network pharmacies are the pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except in an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Buckeye.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, Section C, page 92 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, you can visit the plan's website at http://mmp.buckeyehealthplan.com or call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Member Handbook Supplement or "Waiver Handbook"

This supplement provides additional information for members enrolled in a home and community based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount we or others on your behalf have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Member Services.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs are covered and**

any drug copay amounts for you. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study
- If you have to see a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

You can also update your information by visiting our website at http://mmp.buckeyehealthplan.com. Click on the "Login" button. Log in or create a new account. Then send us a secure message. Call Member Services if you have any questions or need help.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8, Section E, page 120.

Chapter 2: Important phone numbers and resources

This chapter provides you with a quick reference of contact information for Buckeye, the State of Ohio, Medicare, and other useful resources.

Table of Contents

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

A. How to contact Buckeye Member Services

CALL	1-866-549-8289 This call is free. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
FAX	1-866-704-3064
WRITE	Buckeye Health Plan – MyCare Ohio 4349 Easton Way, Suite 400 Columbus, OH 43219 If you are sending us an appeal or complaint, you can use the form in Chapter 9, Section 10.3, page 200. You can also write a letter telling us about your question, problem, complaint, or appeal.
WEBSITE	http://mmp.buckeyehealthplan.com

Contact Member Services about:

- **Questions about the plan**
- **Questions about claims or billing from providers**
- **Member Identification (ID) Cards**

  Let us know if you didn't get your Member ID Card or you lost your Member ID Card.
- **Finding network providers**

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

This includes questions about finding or changing your primary care provider (PCP).

- **Getting long-term services and supports**

  In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by Ohio Medicaid and Buckeye, you may be able to get assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.

- **Understanding the information in your Member Handbook**

- **Recommendations for things you think we should change**

- **Other information about Buckeye**

  You can ask for more information about our plan, including information regarding the structure and operation of Buckeye and any physician incentive plans we operate.

- **Coverage decisions about your health care and drugs**

  A coverage decision is a decision about:

  » your benefits and covered services and drugs, ***or***

  » the amount we will pay for your health services and drugs.

  Call us if you have questions about a coverage decision.

  ➔ To learn more about coverage decisions, see Chapter 9, Sections 5.2 (page 154) and 6.4 (page 173).

- **Appeals about your health care and drugs**

  An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

  ➔ To learn more about making an appeal, see Chapter 9, Section 4, page 149.

- **Complaints about your health care and drugs**

  You can make a complaint about us or any provider or pharmacy. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Chapter 2, Section E, page 20).

  ➔ If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (see Chapter 2, Section A, page 14).

➔ You can send a complaint about Buckeye right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) to ask for help.

➔ You can send a complaint about Buckeye directly to Ohio Medicaid. See page 22 for ways to contact Ohio Medicaid.

➔ You can send a complaint about Buckeye to the MyCare Ohio Ombudsman. Call 1-800-282-1206 (TTY: 1-800-750-0750). This call is free.

➔ To learn more about making a complaint, see Chapter 9, Section 10, page 196.

- **Payment for health care or drugs you already paid for**

  ➔ For more on how to ask us to assist you with a service you paid for or to pay a bill you got, see Chapter 7, Section A, page 110.

  ➔ If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Section 4, page 149 for more on appeals.

B. How to contact your Care Manager

A care manager will work with you to develop a plan that meets your specific health needs. This person helps to manage all your providers, services, and supports. They will work with you, your physicians, and your care team to make sure you get the care you need. You will have a care manager automatically assigned to you. To contact or change your care manager, call the telephone numbers below:

CALL	1-866-549-8289 This call is free. The care manager call line is available 24 hours a day, 7 days a week, 365 days a year. After hours, on weekends and on holidays, your call will be answered by our 24-hour nurse advice call line. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The care manager call line is available 24 hours a day, 7 days a week, 365 days a year. After hours, on weekends and on holidays, your call will be answered by our 24-hour nurse advice call line.
FAX	1-866-704-3064
WRITE	Buckeye Health Plan – MyCare Ohio 4349 Easton Way, Suite 400 Columbus, OH 43219
WEBSITE	http://mmp.buckeyehealthplan.com

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

C. How to contact the 24-Hour Nurse Advice Call Line

Buckeye's Nurse Advice Call Line is called NurseWise. NurseWise is a valuable resource provided to Buckeye members, but it should not replace a visit with your primary care provider (PCP). This call line will provide you guidance on how to use health care and provides information on treatment options and available resources. Calls to NurseWise are free.

CALL	1-866-549-8289. This call is free. NurseWise is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. NurseWise is available 24 hours a day, 7 days a week, 365 days a year.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

D. How to contact the 24-Hour Behavioral Health Crisis Line

The Behavior Health Crisis Line is for members who urgently need to speak to a mental health or substance abuse specialist.

CALL	1-866-549-8289 This call is free. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

E. How to contact the Quality Improvement Organization (QIO)

An organization called KePRO serves as Ohio's QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KePRO is not connected with our plan.

CALL	1-855-408-8557
TTY	1-855-843-4776 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	KEPRO 5201 W Kennedy Blvd, Suite 900 Tampa, FL 33609
EMAIL	medicalaffairs@kepro.com
WEBSITE	www.keproqio.com

Contact KePRO about:

- **Questions about your health care**

  You can make a complaint about the care you got if:

  » You have a problem with the quality of care,

  » You think your hospital stay is ending too soon, ***or***

  » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

F. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Forms, Help & Resources” and then clicking on “Phone numbers & websites.” The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find health & drug plans.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

G. How to contact the Ohio Department of Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and copays except for prescriptions. Medicaid covers long-term care services such as home and community-based "waiver" services and assisted living services and long-term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Medicaid. Buckeye provides your Medicaid covered services through a provider agreement with Ohio Medicaid. If you have questions about the help you get from Medicaid, call the Ohio Medicaid Hotline.

CALL	1-800-324-8680 This call is free. The Ohio Medicaid Hotline is available Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m.
TTY	1-800-292-3572 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Ohio Medicaid TTY number is available Monday through Friday from 7:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 5:00 p.m.
WRITE	Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215
EMAIL	bmhc@medicaid.ohio.gov
WEBSITE	http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address, income, or other insurance. Contact information is available online at: http://jfs.ohio.gov/County/County_Directory.pdf.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan. The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports. The MyCare Ohio Ombudsman is an independent program, and the services are free.

CALL	1-800-282-1206 This call is free. The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 a.m. to 5:00 p.m.
TTY	Ohio Relay Service: 1-800-750-0750 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Ohio Department of Aging Attn: MyCare Ohio Ombudsman 246 N. High Street, 1st Floor Columbus, Ohio 43215-2406
WEBSITE	http://aging.ohio.gov/services/ombudsman/ You can submit an online complaint at: http://aging.ohio.gov/contact/.

Chapter 3: Using the plan's coverage for your health care and other covered services

Table of Contents

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

A. About "services," "covered services," "providers," "network providers," and "network pharmacies"

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, Section D, page 45.

Providers are doctors, nurses, and other people who deliver services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that deliver health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. See Chapter 4, Section D, page 45 for more information.

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. When you use a network pharmacy, you pay nothing for your prescription drugs. See Chapter 6, Section C, page 105 for more information.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

Buckeye covers health care services covered by Medicare and Medicaid. This includes behavioral health, long term care, and prescription drugs.

Buckeye will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- **The care you get must be a plan benefit.** See Chapter 4, Section D, page 45 for information regarding covered benefits, including the plan's Benefits Chart**.**
- **The care must be medically necessary.** *Medically necessary* means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into

a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- **The care you get must be prior authorized by Buckeye when required**. For some services, your provider must submit information to Buckeye and ask for approval for you to get the service. This is called *prior authorization.* See the chart in Chapter 4, Section D, page 45 for more information.
- **You must choose a network provider to be your primary care provider (PCP) to manage your medical care.** Although you do not need approval (called a referral) from your PCP to see other providers, it is still important to contact your PCP before you see a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.

  ➔ To learn more about choosing a PCP, see page 29.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:
  - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 34.
  - » If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. Prior authorization from the plan is generally required for out-of-network services. In this situation, we will cover the care at no cost to you. To learn about getting approval to see an out-of-network provider, see page 29.
  - » The plan covers services you got at out-of-network Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the Provider and Pharmacy Directory.
  - » If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.
  - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - » If you are new to our plan, you may be able to continue to see your current out-of-network providers for a period of time after you enroll. This is called a "transition

period." For more information, go to Chapter 1, Section F, page 7 of this handbook and your *New Member Letter*.

C. Your care team and care manager

Your care team includes a care manager from Buckeye along with anyone you choose (such as a family member and/or caregivers), your providers, and most importantly – you! Care managers are used to ensure you get the best outcome for your care. In order to ensure your care manager understands your health care needs, they will ask questions about your current health care. This will ensure you get the appropriate care coordination. Care coordination is the way your care team works with you, your family, and your providers to ensure all of your needs are coordinated. Our care managers provide both you and your providers' information to make sure you get the most appropriate treatment.

Your care manager helps you manage all of your providers and services. He or she works with your care team to make sure you get the care you need.

- What is care management?
    - Care management is a program used at Buckeye to coordinate care for our members.
- How can you contact your care manager?
    - You can contact your care manager by calling 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week.
- How will your care manager and care team interact with you?
    - Our care managers and care team will work with you to coordinate your care needs. They are here to ensure you get the best outcome for your health care.
- How can you change your care manager?
    - If you want to change your care manager, call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

When you become a member of our plan, you must choose a plan provider to be your PCP. Your PCP is a provider who meets Ohio's requirements to be a PCP and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP.

Your PCP can be one of the following providers, or under certain circumstances such as pregnancy, even a specialist:

- Family practice
- Internal medicine
- General practice
- OB/GYN
- Geriatrics
- Pediatricians
- Certified Nurse Practitioner (CNP) or Physician Assistant (PA)
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)

Your PCP will also coordinate the rest of the covered services you get as a plan member. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital.

- Your PCP determines what specialists and hospitals you will use because they have affiliations with certain specialists and hospitals in our network.
- Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as member of our plan. This includes:
    - x-rays
    - laboratory tests
    - therapies
    - care from doctors who are specialists

- hospital admissions, and
- follow-up care

Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP or specialist will need to get prior authorization (prior approval) from us.

Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8, Section E, page 120 tells you how we will protect the privacy of your medical records and personal health information.

Once you are enrolled in Buckeye, your PCP, together with you and anyone else you choose to have involved (such as a family member and/or care givers), will construct an individualized care plan designed just for you. Your care manager will work with you and your PCP to develop your care plan and to ensure you get the care you need. Your physician is responsible for coordinating all your medical care and for calling upon additional specialists, if necessary. Your care plan will include all of the services that your PCP or plan care manager has authorized for you to get as a member of Buckeye. To ensure that you are receiving the most appropriate care at all times, your PCP or a member of the Care Management Team reviews, approves, and authorizes changes to the care plan, whether adding, changing, or discontinuing services. Your PCP or care manager reassesses your needs at least every 365 days, but more frequently if necessary.

How do you choose your PCP?

You can choose any network PCP listed in the Provider & Pharmacy Directory. Please review our Provider & Pharmacy Directory or call Member Services to choose your PCP. You can contact Member Services by calling 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Changing your PCP

You may change your PCP for any reason. You can change your PCP to another network PCP at any time, up to once a month. Also, it's possible that your PCP might leave our plan's network. If your provider leaves the plan's network, we can help you find a new PCP.

If you wish to change your PCP, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business

day. You will be issued a new ID card showing the new PCP. The change will be effective the first day of the following month.

Under certain circumstances, our providers are obligated to continue care after leaving our network. For specific details contact the plan.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

It is very important to talk to your PCP before you see a plan specialist or certain other providers. The PCP can help to coordinate that visit to the specialist. If a specialist feels you need additional specialty services, the specialist will ask for authorization directly from Buckeye. For information about which services require prior authorization, see the benefits chart in Chapter 4, Section D of this handbook.

If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals because they have affiliations with certain specialists and hospitals in our network. This means that the PCP you select may help determine the specialists you see. If you want to see a plan specialist that your current PCP won't refer you to, you may change your PCP at any time.

Please refer to section above, "Changing your PCP," where we tell you how to change your PCP. If there are specific hospitals you want to use, you must find out whether the doctors you will be seeing use these hospitals.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.

- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a complaint.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

How to get care from out-of-network providers

You may get services from out-of-network providers when providers of specialized services are not available in network. For services to be covered from an out-of-network provider, your in-network provider (usually your PCP) must ask for prior authorization (approval in advance) from Buckeye.

All prior authorization requests will be reviewed by a care manager who is trained to understand care you would get from a specialist and will attempt to determine if the services needed are available within Buckeye's network of specialists.

If the service is not available within our plan's network, your request will be approved. There may be certain limitations to the approval, such as one initial consultation visit or a specified type or amount of services. If the specialist's services are available within your plan's network, the request for services outside the network may be denied as "services available in network". As with any denial, you will have the ability to appeal the determination.

➔ **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you may have to pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

E. How to get long-term services and supports (LTSS)

Long-term supports and services are available to all Buckeye members who meet eligibility requirements. To get long-term supports and services, you can contact your care manager, waiver services coordinator, or PCP. A long-term supports and services (waiver) coordinator will work with you and your care team to identify what services are appropriate to meet your needs. You are able to choose your long-term supports and services (waiver) coordinator from in-network providers.

If you are already receiving long-term services and supports, your Buckeye care manager will work with your providers to make sure your care isn't disrupted.

F. How to get behavioral health services

Behavioral health services are available to all Buckeye members. Most individual outpatient treatments described in Chapter 4 are covered with an in-network provider with prior authorization. For information about which services require prior authorization, see the benefits chart in Chapter 4, Section D of this handbook. To get other behavioral health services please contact your care manager or PCP.

G. How to get transportation services

Buckeye offers up to 15 round-trip visits (30 one-way trips) per member every year to covered health care/dental appointments, WIC appointments, and redetermination appointments with your CDJFS caseworker. Members can call 1-866-549-8289 (TTY: 711) to schedule transportation. Please call 48 hours (two business days) in advance. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

For information specific to waiver transportation services, call your waiver service coordinator.

In addition to the transportation assistance that Buckeye provides, you can also get help with transportation for certain services through the Non-Emergency Transportation (NET)

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

program. Call your local County Department of Job and Family Services for questions or assistance with NET services.

H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson (meaning a person with an average knowledge of health and medicine) could expect it to result in:

- serious risk to your health; ***or***
- serious harm to bodily functions; ***or***
- serious dysfunction of any bodily organ or part; ***or***
- in the case of a pregnant woman, in active labor, meaning labor at a time when either of the following would occur:
  - » There is not enough time to safely transfer you to another hospital before delivery.
  - » The transfer may pose a threat to your health or safety or to that of your unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital, or other appropriate setting. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP or Buckeye.
- **Be sure to tell the provider that you are a Buckeye member.** Show the provider your Buckeye Member ID Card.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Also, if the hospital has you stay,

please make sure Buckeye is called within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. You can contact your care manager by calling 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, Section D, page 45.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call your care manager at 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. By notifying your care manager, this will ensure you get the follow-up care needed to stabilize your condition and/or keep your condition from reoccurring.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health or the health of your unborn child was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider, ***or***
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See Chapter 3, Section H, page 35.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider, ***and***
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

To access urgently needed services, you should go to the nearest urgent care center that is open. If you are seeking urgent care in our service area, you should look in the Provider and Pharmacy Directory for a listing of the urgent care centers in your plan's network, or visit http://mmp.buckeyehealthplan.com.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States or its territories.

Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Buckeye.

Please visit our website for information on how to obtain needed care during a declared disaster: http://mmp.buckeyehealthplan.com.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

I. What if you are billed directly for the full cost of services covered by our plan?

Providers should bill us for providing you covered services. You should not get a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services as soon as possible to give us the information on the bill.

➔ **You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **see Chapter 7, Section A, page 110 to learn what to do.**

What should you do if services are not covered by our plan?

Buckeye covers all services:

- that are medically necessary, ***and***
- that are listed in the plan's Benefits Chart (see Chapter 4, Section D, page 45)*, **and***
- that you get by following plan rules.

➔ If you get services that aren't covered by our plan, **you may have to pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section 4, page 149 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have prior approval from Buckeye to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are, how close you are to reaching them, and what your provider must do to ask to exceed the limit if they think it is medically necessary.

J. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study. Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your care manager should contact Member Services.

When you are in a clinical research study, who pays for what?

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.

- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Ohio Medicaid does not cover clinical research studies.

Learning more

You can learn more about joining a clinical research study by reading "Medicare and Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Our plan covers unlimited days for inpatient hospital care when authorized by the plan. Please see the Benefits Chart in Chapter 4, Section D, page 45 for more information.

L. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. Other types of durable medical equipment will be rented for you by Buckeye. Sometimes you will own the rented item after we pay the rental fee for a certain number of months, and sometimes you will not own the item no matter how long it is rented. Call Member Services to find out whether you will own your item or if it will be rented.

What happens if you switch to Original Medicare?

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. You will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***

- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare.

Chapter 4: Benefits Chart

Table of Contents

A. Understanding your covered services

This chapter tells you what services Buckeye covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 and information about what you pay for drugs is in Chapter 6, Section C.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. See Chapter 3, Section B, page 26 for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or your care manager at 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week.

B. Our plan does not allow providers to charge you for services

Except as indicated above, we do not allow Buckeye providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

➔ **You should never get a bill from a provider for a covered service. If you do, see Chapter 7, Section A, page 110 or call Member Services.**

C. About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your care manager.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.
  - ➔ If Buckeye makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, see Chapter 9, Section 4, page 149.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 29 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization*. Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service. If you are not sure whether a service requires prior authorization, contact Member Services or visit our website at http://mmp.buckeyehealthplan.com.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

D. The Benefits Chart

Preventative Visits

Services covered by our plan	Limitations and exceptions
Annual checkup This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	None.
"Welcome to Medicare" visit If you have been in Medicare Part B for 12 months or less, you can get a one-time "Welcome to Medicare" preventive visit. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. This visit includes: ▪ a review of your health, ▪ education and counseling about the preventive services you need (including screenings and shots), and ▪ referrals for other care if you need it.	None.
Well child check-up (also known as Healthchek) Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.	None.

Preventative Services and Screenings

Services covered by our plan	Limitations and exceptions
Abdominal aortic aneurysm screening The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk.	None.
Alcohol misuse screening and counseling The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner.	None.
Breast cancer screening The plan covers the following services: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms ▪ Annual clinical breast exams	None.
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well.	None.

Services covered by our plan	Limitations and exceptions
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.	None.
Cervical and vaginal cancer screening The plan covers Pap tests and pelvic exams annually for all women.	None.
Colorectal cancer screening For people 50 and older or at high risk of colorectal cancer, the plan covers: ▪ Flexible sigmoidoscopy (or screening barium enema) ▪ Fecal occult blood test ▪ Screening colonoscopy ▪ Guaiac-based fecal occult blood test *or* fecal immunochemical test ▪ DNA based colorectal screening For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	None.
Counseling and interventions to stop smoking or tobacco use The plan covers tobacco cessation counseling and intervention. Tobacco cessation counseling and interventions are available to all plan enrollees.	None.
Depression screening The plan covers depression screening.	None.

Services covered by our plan	Limitations and exceptions
Diabetes screening The plan covers diabetes screening (includes fasting glucose tests). You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).	None.
HIV screening The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.	None.
Immunizations The plan covers the following services: ▪ Vaccines for children under age 21 ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B or Medicaid coverage rules ▪ Other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D, page 107 to learn more.	None.

Services covered by our plan	Limitations and exceptions
Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: ▪ Are aged 55-77, *and* ▪ Have a counseling and shared decision-making visit with your doctor or other qualified provider, *and* ▪ Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer *or* smoke now *or* have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	None.
Obesity screening and therapy to keep weight down The plan covers counseling to help you lose weight.	None.
Prostate cancer screening The plan covers the following services: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test	None.
Sexually transmitted infections (STIs) screening and counseling The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B. The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.	None.

Other Services

Services covered by our plan	Limitations and exceptions
Ambulance and wheelchair van services Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby's life or health. In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary. See also "Transportation for non-emergency services."	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**
Chiropractic services The plan covers: ▪ Diagnostic x-rays ▪ Adjustments of the spine to correct alignment	None.

Services covered by our plan	Limitations and exceptions
Dental services The plan covers the following services: ▪ Routine exams, cleanings and x-rays: » Annually for members 21 and over » Twice annually for members 20 and under ▪ Comprehensive oral exam (one per provider-patient relationship) ▪ Periodic oral exam once every 180 days for members under 21 years of age, and once every 365 days for members age 21 and older ▪ Preventive services including prophylaxis, fluoride for members under age 21 (limited to once every 180 days), sealants, and space maintainers ▪ Routine radiographs/diagnostic imaging ▪ Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services. Comprehensive dental services are provided when medically necessary.	None.

Services covered by our plan	Limitations and exceptions
Diabetic services The plan covers the following services for all people who have diabetes (whether they use insulin or not): ▪ Training to manage your diabetes, in some cases ▪ Supplies to monitor your blood glucose, including: » Blood glucose monitors and test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.	None.

Services covered by our plan	Limitations and exceptions
Durable medical equipment and related supplies Covered durable medical equipment includes, but is not limited to, the following: ▪ Wheelchairs ▪ Oxygen equipment ▪ Canes, crutches, and walkers ▪ IV infusion pumps ▪ Hospital beds ▪ Commodes ▪ Nebulizers ▪ Incontinence garments ▪ Enteral nutritional products ▪ Ostomy and urological supplies ▪ Surgical dressings and related supplies ▪ Speech generating devices For additional types of supplies that the plan covers, see the sections on diabetic services, hearing services, and prosthetic devices. The plan may also cover learning how to use, modify, or repair your item. Your care team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan. We will cover all durable medical equipment that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Emergency care (see also "urgently needed care") *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, ***and*** ▪ needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: ▪ serious risk to your health; ***or*** ▪ serious harm to bodily functions; ***or*** ▪ serious dysfunction of any bodily organ or part; ***or*** ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: » There is not enough time to safely transfer you to another hospital before delivery. » The transfer may pose a threat to your health or to that of your unborn child. In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do. Emergency care is only covered within the United States and its territories. Contact Member Services for details.	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.

Services covered by our plan	Limitations and exceptions
Family planning services The plan covers the following services: ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ▪ Family planning supplies (condom, sponge, foam, film, diaphragm, cap) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions ▪ Treatment for sexually transmitted infections (STIs) ▪ Treatment for AIDS and other HIV-related conditions ▪ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ▪ Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders ▪ Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) **Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.	None.

Services covered by our plan	Limitations and exceptions
Federally Qualified Health Centers The plan covers the following services at Federally Qualified Health Centers: ▪ Office visits for primary care and specialists services ▪ Physical therapy services ▪ Speech pathology and audiology services ▪ Dental services ▪ Podiatry services ▪ Optometric and/or optician services ▪ Chiropractic services ▪ Transportation services ▪ Mental health services **Note:** You can get services from a network or out-of-network Federally Qualified Health Center.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**
Freestanding birth center services	None.
Health and wellness education programs Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline). On-line Provider Directory; On-line Member Website; Medical Advice, Behavioral Health Crisis, and Care Management Support services through toll-free 24 hour, 7 days a week (24/7) call-in systems that are available nationwide.	None.

Services covered by our plan	Limitations and exceptions
Hearing services and supplies The plan covers the following: ▪ Routine hearing exams ▪ Hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) ▪ Hearing aids, batteries, and accessories (including repair and/or replacement). » Two (2) conventional hearing aids are covered once every 4 years when medically necessary » Two (2) digital/programmable hearing aids are covered once every 5 years when medically necessary ▪ Fittings/evaluations for hearing aids	None.

Services covered by our plan	Limitations and exceptions
Home and community-based waiver services The plan covers the following home and community-based waiver services: ▪ Adult day health services ▪ Alternative meals service ▪ Assisted living services ▪ Choices home care attendant ▪ Chore services ▪ Community transition ▪ Emergency response services ▪ Enhanced community living services ▪ Home care attendant ▪ Home delivered meals ▪ Home medical equipment and supplemental adaptive and assistive devices. Limited to a $10,000 benefit every year. ▪ Home modification, maintenance, and repair. Limited to a $10,000 benefit every year. ▪ Homemaker services ▪ Independent living assistance ▪ Nutritional consultation ▪ Out of home respite services ▪ Personal care services ▪ Pest control ▪ Social work counseling ▪ Waiver nursing services ▪ Waiver transportation	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.** These services are available only if your need for long-term care has been determined by Ohio Medicaid. You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. These services require qualification for and enrollment in a state-operated waiver program.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Services covered by our plan	Limitations and exceptions
Home health services The plan covers the following services provided by a home health agency: ▪ Home health aide and/or nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Private duty nursing (may also be provided by an independent provider). Limited to 16 hours every day. ▪ Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally ▪ Medical and social services ▪ Medical equipment and supplies	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Hospice care You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following while you are getting hospice services: ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ▪ Nursing facility care ***Hospice services and services covered by Medicare Part A or B are billed to Medicare:*** ▪ See Section F, page 81 of this chapter for more information. ***For services covered by Buckeye but not covered by Medicare Part A or B:*** ▪ Buckeye will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. ***For drugs that may be covered by Buckeye's Medicare Part D benefit:*** ▪ Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, page 98. ***This benefit is continued on the next page***	If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

Services covered by our plan	Limitations and exceptions
Hospice care (continued) **Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. To reach your care manager, call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.	
Inpatient behavioral health services The plan covers the following services: ▪ Inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital » For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit ▪ Inpatient detoxification care	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Inpatient hospital care The plan covers the following services, and maybe other services not listed here: ▪ Semi-private room (or a private room if it is medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Costs of special care units, such as intensive care or coronary care units ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Needed surgical and medical supplies ▪ Appliances, such as wheelchairs for use in the hospital ▪ Operating and recovery room services ▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ Blood, including storage and administration ▪ Physician/provider services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral ***This benefit is continued on the next page***	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Inpatient hospital care (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If Buckeye provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or cover lodging and travel costs for you and one other person. If transplant services are available at a local Medicare-approved transplant center, transportation and lodging will not be covered by Buckeye.	

Services covered by our plan	Limitations and exceptions
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not reasonable and needed, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here: ▪ Doctor services ▪ Diagnostic tests, like lab tests ▪ X-ray, radium, and isotope therapy, including technician materials and services ▪ Surgical dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: » replace all or part of an internal body organ (including contiguous tissue), or » replace all or part of the function of an inoperative or malfunctioning internal body organ. ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition ▪ Physical therapy, speech therapy, and occupational therapy	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Insect Repellant The plan will make insect repellant available to all enrollees without utilization limits, age or place of residence restrictions. Repellent is covered at a participating pharmacy.	None.
Kidney disease services and supplies The plan covers the following services: ▪ Kidney disease education services to teach kidney care and help you make good decisions about your care ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 26 ▪ Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Note:** Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.	None.

Services covered by our plan	Limitations and exceptions
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan covers three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Buckeye covers the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases ➔ **Chapter 5, Introduction explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6, Section C explains what you pay for your outpatient prescription drugs through our plan.**	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at addiction treatment centers The plan covers the following services at addiction treatment centers: ▪ Ambulatory detoxification ▪ Assessment ▪ Case management ▪ Counseling » Limited to 30 hours per week ▪ Crisis intervention ▪ Intensive outpatient ▪ Alcohol/drug screening analysis/lab urinalysis ▪ Medical/somatic » Limited to 30 hours per week ▪ Methadone administration ▪ Office administered medications for addiction including vivitrol and buprenorphine induction See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at community mental health centers The plan covers the following services at certified community mental health centers: ▪ Mental health assessment/diagnostic psychiatric interview » Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year ▪ Community psychiatric supportive treatment (CPST) services ▪ Counseling and therapy » Limited to 52 hours of combined individual/group therapy per year ▪ Crisis intervention ▪ Pharmacological management » Limited to 24 hours per year ▪ Pre-hospital admission screening ▪ Certain office administered injectable antipsychotic medications ▪ Partial hospitalization » Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care The plan covers the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Durable Medical Equipment, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment: ▪ A nursing home or continuing care retirement community where you lived on the day you became a Buckeye member ***This benefit is continued on the next page***	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.** You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Note that patient liability does not apply to Medicare-covered days in a nursing facility.

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care (continued) You can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment: ▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital Medically necessary Nursing Facility Services are covered by Buckeye Health Plan. Payment for room and board or "patient liability" will apply for long term nursing facility stays, which will be determined by the individual's county JFS caseworker, after the Medicare skilled nursing facility benefit is exhausted. Medicaid-eligible NF stays do not require a 3-day hospital stay.	

Services covered by our plan	Limitations and exceptions
Outpatient mental health care The plan covers mental health services provided by: ▪ a state-licensed psychiatrist or doctor, ▪ a clinical psychologist, ▪ a clinical social worker, ▪ a clinical nurse specialist, ▪ a nurse practitioner, ▪ a physician assistant, ***or*** ▪ any other qualified mental health care professional as allowed under applicable state laws. The plan covers the following services, and maybe other services not listed here: ▪ Clinic services and general hospital outpatient psychiatric services ▪ Day treatment ▪ Psychosocial rehab services	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Outpatient services The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury. The following are examples of covered services: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers ▪ Chemotherapy ▪ Labs and diagnostic tests (for example urinalysis) ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ▪ Imaging (for example x-rays, CTs, MRIs) ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Blood, including storage and administration ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**
Over-the-Counter (OTC) Items The plan covers limited OTC items available via mail order. Contact Buckeye for more information.	Limited to $25 every calendar month for eligible OTC items. Any unused amount cannot be carried over to the next month.

Services covered by our plan	Limitations and exceptions
Physician/provider services, including doctor's office visits The plan covers the following services: ▪ Health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for patients in rural areas or other places approved by Medicare ▪ Second opinion by another network provider before a medical procedure ▪ Non-routine dental care. Covered services are limited to: » surgery of the jaw or related structures, » setting fractures of the jaw or facial bones, » pulling teeth before radiation treatments of neoplastic cancer, ***or*** » services that would be covered when provided by a physician.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**
Podiatry services The plan covers the following services: ▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma ▪ Routine foot care for members with conditions affecting the legs, such as diabetes	None.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Services covered by our plan	Limitations and exceptions
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. The following are examples of covered prosthetic devices: ▪ Colostomy bags and supplies related to colostomy care ▪ Pacemakers ▪ Braces ▪ Prosthetic shoes ▪ Artificial arms and legs ▪ Breast prostheses (including a surgical brassiere after a mastectomy) ▪ Dental devices The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section (page 80) for details.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Rehabilitation services ▪ Outpatient rehabilitation services » The plan covers physical therapy, occupational therapy, and speech therapy. » You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. ▪ Cardiac (heart) rehabilitation services » The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. » The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. ▪ Pulmonary rehabilitation services » The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).	**Prior Authorization (approval in advance) may be required for outpatient rehabilitation services. Prior Authorization is not required for cardiac (heart) rehabilitation services or pulmonary rehabilitation services. Please contact the plan for details.**
Rural Health Clinics The plan covers the following services at Rural Health Clinics: ▪ Office visits for primary care and specialists services ▪ Clinical psychologist ▪ Clinical social worker for the diagnosis and treatment of mental illness ▪ Visiting nurse services in certain situations **Note:** You can get services from a network or out-of-network Rural Health Clinic.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Specialized Recovery Services (SRS) Program If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to receive SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program: ▪ **Recovery Management** - Recovery managers will work with you to: » develop a person-centered care plan which reflects your personal goals and desired outcomes, » regularly monitor your plan through regular meetings, and » provide information and referrals. ▪ **Individualized Placement and Support-Supported Employment (IPS-SE)** – Supported employment services can: » help you find a job if you are interested in working, » evaluate your interests, skills, and experiences as they relate to your employment goals, and » provide ongoing support to help you stay employed. ***This benefit is continued on the next page***	If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills. Individuals must meet specified financial, clinical, needs and risk eligibility criteria. Per service limits apply.

Services covered by our plan	Limitations and exceptions
Specialized Recovery Services (SRS) Program (continued) ▪ **Peer Recovery Support:** » peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, and » goals are included in a care plan you design based on your preferences and the availability of community and supports. The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being and independence.	
Transportation for non-emergency services (see also "Ambulance and wheelchair van services") You are covered for 30 one-way trips to plan-approved locations every year. Types of non-emergency transportation include: • Wheelchair equipped van • Taxicab Please call Member Services or your care manager for additional information. If you must travel 30 miles or more from your home to get covered health care services, Buckeye will provide transportation to and from the provider's office. ➔ In addition to the transportation assistance that Buckeye provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.** Waiver Transportation - Waiver transportation services and the provider of such services must be identified on the waiver service plan. Waiver transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's waiver service plan.

Services covered by our plan	Limitations and exceptions
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, ***or*** ▪ a sudden medical illness, ***or*** ▪ an injury, ***or*** ▪ a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. Buckeye covers emergency or urgently needed care whenever you need it, anywhere in the United States or its territories.	Urgently needed services are only covered within the United States and its territories. Contact Member Services for details.

Services covered by our plan	Limitations and exceptions
Vision care The plan covers the following services: ▪ One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: » per 12-month period for members under 21 and over 59 years of age; ***or*** » per 24-month period for members 21 through 59 years of age. ▪ Vision training ▪ Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: » Annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. » One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older. » One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.)	None.

E. Accessing services when you are away from home or outside of the service area

If you are away from home or outside of our service area (see Chapter 1, Section D, page 6) and need medical care, you may get emergency or urgently needed care anywhere in the United States or its territories. We do not cover emergency or urgently needed care or any other care that you get outside the United States or its territories. To access emergency or urgent care services, you should go to the nearest emergency room or urgent care center. See Chapter 3, Section H, page 34 for more information.

F. Benefits covered outside of Buckeye

The following services are not covered by Buckeye but are available through Medicare. Call Member Services to find out about services not covered by Buckeye but available through Medicare.

Hospice Care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.

See the Benefits Chart in Section D of this chapter for more information about what Buckeye pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Buckeye's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, page 98.

Note: If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. To reach your care manager, call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week.

G. Benefits *not* covered by Buckeye, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section 4, page 149.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages 38-39 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- Full-time nursing care in your home.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

Buckeye also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D, page 67.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page 97 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

Show your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

You should **always** show the pharmacy your Member ID Card when you fill a prescription to avoid any problems. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

➔ If you need help getting a prescription filled, you can contact Member Services, Buckeye's 24-hour medical advice line, or your care manager.

What if you want to change a prescription to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

➔ If you need help finding a network pharmacy, you can contact Member Services or your care manager.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy. If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service allows you to order up to a 90-day supply. A 90-day supply has the same copay as a one-month supply.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The forms are also available on our website at http://mmp.buckeyehealthplan.com.

Usually, a mail-order prescription will get to you within 16 days. If your order is delayed, contact Homescripts at 1-888-239-7690 (TTY: 711). Representatives are available Monday to Friday from 7 a.m. to 7 p.m. Eastern Time (ET) and Saturdays from 9 a.m. to 12 p.m. Eastern Time (ET).

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy gets from you**

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets directly from your provider's office**

   After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **Refills on mail-order prescriptions**

   For refills, please contact your pharmacy 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can provide this information by calling Homescripts at 1-888-239-7690 (TTY: 711). Representatives are available Monday to Friday from 7 a.m. to 7 p.m. Eastern Time (ET) and Saturdays from 9 a.m. to 12 p.m. Eastern Time (ET).

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- You travel outside the plan's service area, require a prescription fill and cannot access or obtain medication at a network pharmacy.
- You are unable to obtain medication in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides service 24 hours/7 days a week.
- Due to a federal disaster or other public health emergency in your geographic area.
- Generally, we will cover a one-time fill, up to a 30-day supply at an out-of-network pharmacy in these situations.

➔ In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

If you use an out-of-network pharmacy, you may have to pay the full cost when you get your prescription.

➔ If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7, Section A, page 110.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under your Medicaid benefits.

The Drug List includes both brand-name and generic drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at http://mmp.buckeyehealthplan.com. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Buckeye will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, Section 4, page 149.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Buckeye for free, but they are not considered part of your outpatient prescription drug benefits.

- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of three tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 (Generic Drugs) includes generic drugs. This is the lowest tier.
- Tier 2 (Brand Drugs) includes brand drugs.
- Tier 3 (Non-Medicare Rx / OTC Drugs) includes both generic and brand drugs. This is the highest tier.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

➔ Chapter 6, Section C, page 105 tells the amount you pay for drugs in each tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is

safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 170.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, if there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Buckeye before you fill your prescription. If you don't get approval, Buckeye may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at http://mmp.buckeyehealthplan.com.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above (Section C, page 92), some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. **The drug you have been taking:**
   - is no longer on the plan's Drug List, ***or***
   - was never on the plan's Drug List, ***or***
   - is now limited in some way.

2. You must be in one of these situations:

- **You were in the plan last year and do not live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for up to a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. You must fill the prescription at a network pharmacy.

- **You are new to the plan and do not live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for up to a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. You must fill the prescription at a network pharmacy.

- **You were in the plan last year and live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. The total supply will be for up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You are new to the plan and live in a long-term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The total supply will be for up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- Throughout the plan year, you may have a change in your treatment setting (the place where you get and take your medicine) because of the level of care you require. Such transitions may include, but are not limited to:
    - Members who are discharged from a hospital or skilled-nursing facility to a home setting
    - Members who are admitted to a hospital or skilled-nursing facility from a home setting
    - Members who transfer from one skilled-nursing facility to another and are served by a different pharmacy
    - Members who end their skilled-nursing facility Medicare Part A stay (where payments include all pharmacy charges) and who now need to use their Part D plan benefit
    - Members who give up Hospice Status and go back to standard Medicare Part A and B coverage
    - Members discharged from chronic psychiatric hospitals with highly individualized drug regimes

  For these changes in treatment settings, Buckeye will cover as much as a 31-day temporary supply of a Part D-covered drug when you fill your prescription at a pharmacy. If you change treatment settings multiple times within the same month, you may have to request an exception or prior authorization and get approval for continued coverage of your drug. We will review these requests for continuation of therapy on a case-by-case basis when you are on a stabilized drug regimen that, if changed, is known to have risks.

➔ To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**

  You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

➔ To learn more about asking for an exception, see Chapter 9, Section 6.2, page 170.

➔ If you need help asking for an exception, you can contact Member Services or your care manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, Section 6.2, page 170.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care

facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership, until we have given you up to a 98-day supply. The first supply will be for up to a 31-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 170.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

➔ To learn more about the hospice benefit, see Chapter 4, Section D, page 60.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

➔ If you have any questions about these programs, please contact Member Services or your care manager.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Table of Contents

Introduction

This chapter tells you about your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Medicaid.

Because you are eligible for Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **The plan’s *List of Covered Drugs.*** We call this the “Drug List.” It tells you:
  - » Which drugs the plan pays for
  - » Which of the three tiers each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at http://mmp.buckeyehealthplan.com. The Drug List on the website is always the most current.
- **Chapter 5 of this Member Handbook.** Chapter 5, Introduction, page 86 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **The plan’s *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 87.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of your total drug costs. This is the amount of money the plan pays (or others on your behalf pay) for your prescriptions.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.

➔ We offer coverage of drugs not covered under Medicare. To find out which drugs our plan covers, see the Drug List.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, and that Medicare pays for you, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill, what you pay, and what Medicare pays for you.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You should give us copies of your receipts when you buy covered drugs at an out-of-network pharmacy.

➔ If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7, Section A, page 110 for information about what to do.

3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With Buckeye, you pay nothing for covered drugs as long as you follow the plan's rules.

The plan's tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of three tiers. You have no copays for prescription and OTC drugs on Buckeye's Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 (Generic Drugs) includes generic drugs.
- Tier 2 (Brand Drugs) includes brand drugs.
- Tier 3 (Non-Medicare Rx / OTC Drugs) includes both generic and brand drugs.

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5, Section A, page 87 or the *Provider and Pharmacy Directory.*

How much do you pay?

Your share of the cost when you get a *one-month or long-term* supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. See Chapter 5, Section A, page 87 for details.
Tier 1 (Generic Drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Tier 2 (Brand Drugs)	$0 copay	$0 copay	$0 copay	$0 copay
Tier 3 (Non-Medicare Rx / OTC Drugs)	$0 copay	$0 copay	$0 copay	$0 copay

➔ For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine.** For example, sometimes you may get the vaccine as a shot given to you by your doctor.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Buckeye to ensure that you do not have any upfront costs for a Part D vaccine.

How much you pay for a vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4, Section D, page 48.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay nothing for the vaccine.
   - Some states do not allow pharmacies to give shots.

2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
   - You will pay nothing to the doctor for the vaccine.
   - Our plan will pay for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.
3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay nothing for the vaccine.
   - Our plan will pay for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Table of Contents

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

A. When you can ask us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A *network provider* is a provider who works with the health plan.

If you get a bill for health care or drugs, call Member Services or send the bill to us. To send us a bill, see page 110.

- If you have not paid the bill, we will pay the provider directly if the services or drugs are covered and you followed all the rules in the Member Handbook.
- If you have paid the bill, the services or drugs are covered, and you followed all the rules in the Member Handbook, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

➔ Contact Member Services or your care manager if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are some examples of times when you may need to ask our plan to assist you with a payment you made or a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   You should always tell the provider you are a member of Buckeye and ask the provider to bill the plan.

   - If you pay the full amount when you get the care, you can ask to have the full amount refunded. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
     - » If the provider should be paid, we will pay the provider directly.
     - » If you have already paid for the service, we will work with the provider to refund your payment.

2. **When a network provider sends you a bill**

   Network providers must always bill the plan for covered services.

- We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will work with the provider to refund your payment amount for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled in an emergency situation

We will cover prescriptions filled at out-of-network pharmacies in emergency situations only. Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- When you are out of the area, require a prescription filled unexpectedly, and are unable to obtain medications at a network pharmacy.
- During a declared disaster in your geographic area. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. See Chapter 3, Section H, page 36 for information on getting care during a disaster.
- Generally, we cover up to a 30-day supply of drugs filled at an out-of-network pharmacy only in limited, non-routine circumstances when a network pharmacy is not available.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

You can always contact Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or your care manager at 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week, if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 200 or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at http://mmp.buckeyehealthplan.com.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

B. How to avoid payment problems

1. **Always ask the provider if the service is covered by Buckeye.**

   Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked Buckeye for a coverage decision (see Chapter 9, Section 5.2, page 154), got a final decision that the service is not covered, and decided that you still want the service even though the plan does not cover it.

2. **Get plan approval before seeing an out-of-network provider.**

   An exception to this rule is if you need out-of-network emergency or urgent care services. Another exception is if you get services at Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the Provider and Pharmacy Directory.

   If you get care from an out-of-network provider, ask the provider to bill Buckeye. If the out-of-network provider is approved by Buckeye, you should not have to pay anything. If the out-of-network provider will not bill Buckeye and you pay for the service, call Member Services as soon as possible to let us know.

   ➔ Please remember that in most situations you must get plan approval before you can see an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval as indicated above, we may not pay for services you get from an out-of-network provider. If you have questions about your transition of care period, whether you need approval to see a certain provider, or need help in finding a network provider, call Member Services.

3. **Follow the rules in the Member Handbook when getting services.**

   See Chapter 3, Section B, page 26 for the rules about getting your health care, behavioral health, and other services. See Chapter 5, Introduction, page 86 for the rules about getting your outpatient prescription drugs.

4. **Use the Provider and Pharmacy Directory to find network providers.**

   If you do not have a Provider and Pharmacy Directory, you can call Member Services to ask for a copy or go online at http://mmp.buckeyehealthplan.com for the most up-to-date information.

5. Always carry your Member ID Card and show it to the provider or pharmacy when getting care.

If you forgot your Member ID Card, ask the provider to call our plan at 1-866-296-8731 (TTY: 711) from 8 a.m. to 5 p.m., Monday through Friday. If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Chapter 8: Your rights and responsibilities

Table of Contents

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs and state laws about the Medicaid program. Other federal and state laws may apply too.

B. You have a right to get information in a way that meets your needs

Each year you are in our plan, we must tell you about the plan's benefits and your rights in a way that you can understand.

➔ To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages.

➔ Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To get materials in Spanish, or to get materials in another format, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You may also write to Buckeye Health Plan – MyCare Ohio, 4349 Easton Way, Suite 400, Columbus, OH 43219. You may also ask that we send you future materials in this same language or format.

➔ If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also contact the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call 7-1-1.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Usted tiene derecho a que le proporcionemos información de una manera que satisfaga sus necesidades

Cada año que usted permanezca en nuestro plan, debemos informarle sobre los beneficios del plan y sus derechos de manera que usted pueda comprender.

➔ Para obtener información de una manera que usted pueda comprender, llame a Servicios para afiliados. Nuestro plan cuenta con personas que pueden responder las preguntas en diferentes idiomas.

➔ Nuestro plan también puede ofrecerle materiales en otros idiomas que no sean el inglés y en formatos como tamaño de letra grande, braille, o audio. Para obtener los materiales en español o en otro formato, llame a Servicios para afiliados al 1-866-549-8289 (TTY: 711) de 8 a. m. a 8 p. m., de lunes a viernes. Luego del horario de atención, los fines de semana y los días feriado, es posible que se le pida que deje un mensaje. Le devolveremos la llamada durante el próximo día hábil. También puede escribir a Buckeye Health Plan – MyCare Ohio, 4349 Easton Way, Suite 400, Columbus, OH 43219. También puede pedir que en el futuro le enviemos materiales en este mismo idioma o formato.

➔ Si tiene dificultad para obtener información sobre nuestro plan debido a problemas relacionados con el idioma o una discapacidad y desea presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar durante las 24 horas, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede comunicarse con la línea directa de Ohio Medicaid al 1-800-324-8680 de lunes a viernes de 7:00 a. m. a 8:00 p. m y los sábados de 8:00 a. m. a 5:00 p. m. Los usuarios de TTY deben llamar al 7-1-1.

C. We must treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Age
- Appeals
- Behavior
- Claims experience
- Color
- Creed
- Ethnicity
- Evidence of insurability
- Genetic information
- Gender identity
- Geographic location within the service area
- Health status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation. You have the right to be treated with respect and with regard for your dignity and privacy.

We cannot deny services to you or punish you for exercising your rights. Exercising your rights will not affect the way our plan, our network providers, or the Ohio Department of Medicaid treats you.

➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also visit http://www.hhs.gov/ocr for more information.

➔ You can also call the Ohio Department of Job and Family Services Bureau of Civil Rights at 1-866-227-6353 (TTY 1-866-221-6700).

➔ If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

D. We must ensure that you get timely access to covered services and drugs

If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

As a member of our plan:

- You have the right to get all services that Buckeye must provide and to choose the provider that gives you care whenever possible and appropriate.
- You have the right to be sure that others cannot hear or see you when you are getting medical care.
- You have the right to choose a primary care provider (PCP) in the plan's network. A *network provider* is a provider who works with the health plan.
  - » Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a network gynecologist or another network women's health specialist for covered women's health services without getting a referral. A *referral* is a written order from your primary care provider.
- You have the right to get covered services from network providers within a reasonable amount of time. This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, Section B, page 26.

Chapter 9, Section 10, page 196 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section 4, page 149 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

E. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- You have the right to be given information about your health. This information may also be available to someone who you have legally authorized to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to Federal laws.
  - » We are required to give your health and drug information to Medicaid. If Medicaid releases your information for research or other uses, it will be done according to federal and state laws.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records if it isn't to transfer the records to a new provider.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

BUCKEYE HEALTH PLAN – MYCARE OHIO (MEDICARE-MEDICAID PLAN) NOTICE OF PRIVACY PRACTICES

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

Covered Entities Duties:

Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Buckeye Health Plan – MyCare Ohio (MMP) is required by law to keep the privacy of your protected health information (PHI). We must give you this Notice. It includes our legal duties and privacy practices related to your PHI. We must follow the terms of the current notice. We must let you know if there is a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It describes your rights to access, change and manage your PHI. It also says how to use your rights.

Buckeye Health Plan – MyCare Ohio (MMP) can change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have. We can also make it effective for any of your PHI we get in the future. Buckeye Health Plan – MyCare Ohio will promptly update and get you this Notice whenever there is a material change to the following stated in the notice:

- The Uses and Disclosures

- Your Rights
- Our Legal Duties
- Other privacy practices stated in the notice

Updated notices will be on our website. We will also mail you or email you a copy on request.

Uses and Disclosures of Your PHI:

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

Treatment. We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. We do this to coordinate your treatment among providers. We also do this to help us with prior authorization decisions related to your benefits.

Payment. We may use and disclose your PHI to make benefit payments for the healthcare services you received. We may disclose your PHI for payment purposes to another health plan, a healthcare provider, or other entity. This is subject to the federal Privacy Rules. Payment activities may include:

- processing claims
- determining eligibility or coverage for claims
- issuing premium billings
- reviewing services for medical necessity
- performing utilization review of claims

HealthCare Operations. We may use and disclose your PHI to perform our health care operations. These activities may include:

- providing customer services
- responding to complaints and appeals
- providing case management and care coordination
- conducting medical review of claims and other quality assessment
- improvement activities

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

- quality assessment and improvement activities
- reviewing the competence or qualifications of health care professionals
- case management and care coordination
- detecting or preventing health care fraud and abuse.

Appointment Reminders/Treatment Alternatives. We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us. We may also use or disclose it to give you information about treatment alternatives. We may also use or disclose it for other health-related benefits and services. For example, information on how to stop smoking or lose weight.

As Required by Law. If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI. We do this when the use or disclosure complies with the law. The use or disclosure is limited to the requirements of the law. There could other laws or regulations that conflict. If this happens, we will comply with the more restrictive laws or regulations.

Public Health Activities. We may disclose your PHI to a public health authority to prevent or control disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA). We can do this to ensure the quality, safety or effectiveness products or services under the control of the FDA.

Victims of Abuse and Neglect. We may disclose your PHI to a local, state, or federal government authority. This includes social services or a protective services agency authorized by law to have these reports. We will do this if we have a reasonable belief of abuse, neglect or domestic violence.

Judicial and Administrative Proceedings. We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:

- an order of a court
- administrative tribunal
- subpoena

- summons
- warrant
- discovery request
- similar legal request.

Law Enforcement. We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

- court order
- court-ordered warrant
- subpoena
- summons issued by a judicial officer
- grand jury subpoena

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

Coroners, Medical Examiners and Funeral Directors. We may disclose your PHI to a coroner or medical examiner. This may be needed, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as needed, to carry out their duties.

Organ, Eye and Tissue Donation. We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

- cadaveric organs
- eyes
- tissues

Threats to Health and Safety. We may use or disclose your PHI if we believe, in good faith, that it is needed to prevent or lessen a serious or imminent threat. This includes threats to the health or safety of a person or the public.

Specialized Government Functions. If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

- to authorized federal officials for national security
- to intelligence activities
- the Department of State for medical suitability determinations
- for protective services of the President or other authorized persons

Workers' Compensation. We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law. These are programs that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations. We may disclose your PHI in an emergency situation, or if you are unable to respond or are not present. This includes to a family member, close personal friend, authorized disaster relief agency, or any other person you told us about. We will use professional judgment and experience to decide if the disclosure is in your best interests. If it is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Research. In some cases, we may disclose your PHI to researchers when their clinical research study has been approved. They must have safeguards in place to ensure the privacy and protection of your PHI.

Verbal Agreement to Uses and Disclosure Your PHI

We can take your verbal agreement to use and disclose your PHI to other people. This includes family members, close personal friends or any other person you identify. You can object to the use or disclosure of your PHI at the time of the request. You can give us your verbal agreement or objection in advance. You can also give it to us at the time of the use or disclose. We will limit the use or disclosure of your PHI in these cases. We limit the information to what is directly relevant to that person's involvement in your healthcare treatment or payment.

We can take your verbal agreement or objection to use and disclose your PHI in a disaster situation. We can give it to an authorized disaster relief entity. We will limit the use or disclosure of your PHI in these cases. It will be limited to notifying a family member, personal representative or other person responsible for your care of your location and general condition. You can give us your verbal agreement or objection in advance. You can also give it to us at the time of the use or disclosure of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

- *Sale of PHI.* We will request your written approval before we make any disclosure that is deemed a sale of your PHI. A sale of your PHI means we are getting paid for disclosing the PHI in this manner.
- *Marketing.* We will request your written approval to use or disclose your PHI for marketing purposed with limited exceptions. For examples, when we have face-to-face marketing communications with you. Or, when we give promotional gifts of nominal value.
- *Additional Restrictions on Use and Disclosure.* Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. “Highly confidential information” may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
    - HIV/AIDS;
    - Mental health;
    - Genetic tests;
    - Alcohol and drug abuse;
    - Sexually transmitted diseases and reproductive health information; and
    - Child or adult abuse or neglect, including sexual assault.

All other uses and disclosures of your PHI not described in this Notice will be made only with your written approval. You may take back your approval at any time. The request to take back approval must be in writing. Your request to take back approval will go into effect as soon as you request it. There are two cases it won’t take effect as soon as you request it. The first case is when we have already taken actions based on past approval. The second case is before we received your written request to stop.

Your Rights

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

- *Right to Request Restrictions.* You have the right to ask for restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations. You can also ask for disclosures to persons involved in your care or payment of your care. This includes family members or close friends. Your request should state the restrictions you are asking for. It should also say to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request. We will not comply if the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or healthcare operations to a health plan when you have paid for the service or item out of pocket in full.

- *Right to Request Confidential Communications.* You have the right to ask that we communicate with you about your PHI in other ways or locations. This right only applies if the information could endanger you if it is not communicated in other ways or locations. You do not have to explain the reason for your request. However, you must state that the information could endanger you if the change is not made. We must work with your request if it is reasonable and states the other way or location where your PHI should be delivered.

- *Right to Access and Receive a Copy of your PHI.* You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may ask that we give copies in a format other than photocopies. We will use the format you ask for unless we cannot practicably do so. You must ask in writing to get access to your PHI. If we deny your request, we will give you a written explanation. We will tell you if the reasons for the denial can be reviewed. We will also let you know how to ask for a review or if the denial cannot be reviewed.

- *Right to Change your PHI.* You have the right to ask that we change your PHI if you believe it has wrong information. You must ask in writing. You must explain why the information should be changed. We may deny your request for certain reasons. For example, if we did not create the information you want changed and the creator of the PHI is able to perform the change. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision. We will attach your statement to the PHI you ask that we change. If we accept your request to change the information, we will make reasonable efforts to

inform others of the change. This includes people you name. We will also make the effort to include the changes in any future disclosures of that information.

- *Right to Receive an Accounting of Disclosures.* You have the right to get a list of times within the last 6 year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, healthcare operations, or disclosures you authorized and certain other activities. If you ask for this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will give you more information on our fees at the time of your request.
- *Right to File a Complaint.* If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us. You can also do this by phone. Use the contact information at the end of this Notice. You can also submit a written complaint to the U.S. Department of Health and Human Services (HHS). See the contact information on the HHS website at www.hhs.gov/ocr. If you request, we will provide you with the address to file a written complaint with HHS. **WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.**
- *Right to Receive a Copy of this Notice.* You may ask for a copy of our Notice at any time. Use the contact information listed at the end of the Notice. If you get this Notice on our website or by email, you can request a paper copy of the Notice.

Contact Information

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

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan)
Attn: Privacy Official
4349 Easton Way, Suite 400
Columbus, OH 43219
1-866-549-8289 (TTY: 711). Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

F. We must give you information about the plan, its network providers, and your covered services

As a member of Buckeye, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. This is a free service. Buckeye can provide materials in alternative languages, such as Spanish. We can also give you information in large print, braille, or audio.

If you want any of the following, call Member Services:

- **Information about how to choose or change plans**
- **Information about our plan, including but not limited to:**
  - » Financial information
  - » How the plan has been rated by plan members
  - » The number of appeals made by members
  - » How to leave the plan
- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change primary care providers (PCP). You can change your PCP to another network PCP at any time. Any change is effective the first of the following month. We must send you something in writing that says who the new PCP is and the date the change began.
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network

  ➔ For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at http://mmp.buckeyehealthplan.com.
- **Information about covered services and drugs and about rules you must follow, including:**
  - » Services and drugs covered by the plan
  - » Limits to your coverage and drugs

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

  - » Rules you must follow to get covered services and drugs

- **Information about why something is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made
  - » Asking us to pay for a bill you have got

G. Network Providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, Section A, page 110.

H. You have the right to get your Medicare and Part D coverage from original Medicare or another Medicare plan at any time by asking for a change

You have the right to get your Medicare health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. However, you must continue to get your Medicaid services from a MyCare Ohio plan. If you want to make a change, you can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY users should call 7-1-1), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.

I. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the kinds of treatment, provided in a way appropriate to your condition and ability to understand.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another qualified network provider before deciding on treatment. If a qualified network provider is not able to see you, we will arrange a visit with a non-network provider at no cost to you.
- **You can say "no.**" You have the right to refuse any treatment or therapy. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you say no to treatment, therapy or taking a drug, the doctor or Buckeye must talk to you about what could happen and they must put a note in your medical record. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You can ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Sections 5.2 (page 154) and 6.4 (page 173) tell how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles.** You have the right to refuse treatment from a student.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a *living will* and a *power of attorney for health care*.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid, such as the Ohio Department of Job and Family Services, the Ohio Department of Aging, and the Ohio Department of Health, may also have advance directive forms. The forms are also currently available on the following website: http://proseniors.org/Law_Library/Health/Advance_Dir.html.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Ohio Department of Health by calling 1-800-342-0553 or emailing HCComplaints@odh.ohio.gov.

You Have the Right: Using Advance Directives to State Your Wishes about Your Medical Care

People often worry about the medical care they would get if they became too sick to make their wishes known.

Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

This document explains your rights under Ohio law to accept or refuse medical care. The document also explains how you can state your wishes about the care you would want if you could not choose for yourself. This document does not contain legal advice, but will help you understand your rights under the law.

What are my rights to choose my medical care?

You have the right to choose your own medical care. If you do not want a certain type of care, you have the right to tell your doctor you do not want it.

What if I am too sick to decide? What if I cannot make my wishes known?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you are able to act for yourself. The form tells your doctors what you want done if you can’t make your wishes known.

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use: a Living Will, a Do Not Resuscitate (DNR) Order, a Health Care Power of Attorney (also known as a Durable Power of Attorney for Health Care) and a Declaration for Mental Health Treatment. You fill out an advance directive while you are able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

Do I have to fill out an advance directive before I get medical care?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

Who can fill out an advance directive?

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

Do I need a lawyer?

No, you do not need a lawyer to fill out an advance directive.

Do the people giving me medical care have to follow my wishes?

Yes, if your wishes follow state law. However, a person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

Living Will

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- in a coma that is not expected to end, - OR –
- beyond medical help with no hope of getting better and can't make your wishes known, - OR –
- expected to die and are not able to make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

Do Not Resuscitate Order

A Do Not Resuscitate (DNR) Order is an order written by a doctor or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, that instructs health care providers not to do cardiopulmonary resuscitation (CPR). In Ohio, there are two types of DNR Orders: (1) DNR Comfort Care, and (2) DNR Comfort Care – Arrest. You should talk to your doctor about DNR options.

Health Care Power of Attorney

A Health Care Power of Attorney is different from other types of powers of attorney. This document talks only about a Health Care Power of Attorney, not about other types of powers of attorney. A Health Care Power of Attorney allows you to choose someone to carry out your

wishes for your medical care. The person acts for you if you cannot act for yourself. This could be for a short time period or for a long time period.

Who should I choose?

You can choose any adult relative or friend whom you trust to act for you when you cannot act for yourself. Be sure to talk with the person about what you want. Then write down what medical care you do or do not want. You should also talk to your doctor about what you want. The person you choose must follow your wishes.

When does my Health Care Power of Attorney take effect?

The form takes effect only when you can't choose your care for yourself. The form allows your relative or friend to stop life support only in the following circumstances:

- if you are in a coma that is not expected to end, - OR –
- if you are expected to die.

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows you, while capable, to appoint a representative to make decisions on your behalf when you lack the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. For example, you can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

What is the difference between a Health Care Power of Attorney and a Living Will?

Your Living Will explains, in writing, your wishes about the use of life-support methods if you are unable to make your wishes known. Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you cannot act for yourself.

If I have a Health Care Power of Attorney, do I need a Living Will, too?

You may want both. Each addresses different parts of your medical care.

Can I change my advance directives?

Yes, you can change your advance directives whenever you want. It is a good idea to look over your advance directives from time to time to make sure they still say what you want and that they cover all areas.

If I don't have an advance directive, who chooses my medical care when I can't?

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and cannot act for yourself.

Where do I get advance directive forms?

Many of the people and places that give you medical care have advance directive forms. You may also be able to get these forms from Midwest Care Alliance's website at: www.midwestcarealliance.org.

What do I do with my forms after filling them out?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends about what you have done. Do not just put these forms away and forget about them.

Organ and Tissue Donation

Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

(1) You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card, -OR-

(2) You may register online for organ donation through the Ohio Donor Registry website: www.donatelifeohio.org.

J. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section 3, page 148 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint. We will also send you a notice when you can make an appeal directly to the Bureau of State Hearings within the Ohio Department of Job and Family Services.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

You are free to exercise all of your rights knowing that Buckeye, our network providers, Medicare, and the Ohio Department of Medicaid will not hold it against you.

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 118 you can get help in these ways:

- You can **call Member Services**.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can **call the MyCare Ohio Ombudsman** in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2, Section H, Page 23 for more information about this organization.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Member Services**.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m.
- You can **contact Medicare**.

  - » You can visit the Medicare website to read or download “Medicare Rights & Protections.” (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- You can **call the MyCare Ohio Ombudsman** in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2, Section H, Page 23 for more information about this organization.

K. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
  - » For details about your covered services, see Chapter 3, Section B, page 26, and Chapter 4, Section D, page 45. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapter 5, Introduction, page 86, and Chapter 6, Section C, page 105.
- **Tell us about any other health or prescription drug coverage you have.** We are required to make sure you are using all of your coverage options when you get health care Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your Member ID Card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
  - » Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - » Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.

  - » If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - » Medicare Part A and Medicare Part B premiums. For nearly all Buckeye members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.
  - » If you get any services or drugs that are not covered by our plan, you may have to pay for the service or drug.

  ➔ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Section 4, page 149 to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1, Section D, page 6 tells about our service area. We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2, Section F, page 21 and Section G, page 22 for phone numbers for Medicare and Medicaid.
  - » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you. You must also notify your County Caseworker at the local Department of Job and Family Services.

- **Call Member Services for help if you have questions or concerns.**

L. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights to ask for a coverage decision, an appeal or make a complaint. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter explains the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services. **You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750) to help guide you through your problem.**

Table of Contents

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. You can contact any of the following resources for help.

Getting help from Buckeye's Member Services

Member Services can help you with any problems or complaints about your health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at 1-866-549-8289 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.
- Visit our website at http://mmp.buckeyehealthplan.com to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 202 of this chapter or call Member Services and ask us to mail you a form.
- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your Buckeye Member ID Card, and your address and telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

Buckeye Health Plan – MyCare Ohio
Attn: Appeals and Grievances -- Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do about your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The call is free. You can also visit the Ohio Department of Medicaid website at http://www.medicaid.ohio.gov.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman helps you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8:00 a.m. to 5:00 p.m. You can also submit an online complaint at: http://aging.ohio.gov/contact. The services are free.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or other provider that requested the service can submit a Level 1 appeal on your behalf.
  - » If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name him or her as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your “representative.”

  - » If you want someone to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at http://mmp.buckeyehealthplan.com. The form gives the person permission to act for you. You must give us a copy of the signed form.
  - » We will also accept a letter or other appropriate form to authorize your representative.

- You can talk to a lawyer. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

Section 3: Problems with your benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care, prescription drugs, or long-term services and supports are covered or not, the way in which they are covered, and problems related to the plan's denial of payment for items and services.)

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go to **Section 4: "Coverage decisions and appeals" on page 149.**	Skip ahead to **Section 10: "How to make a complaint" on page 196.**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment denials.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources listed in Section 2.1 on page 145.

Section 4.2: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5 on page 152** gives you information if you have problems getting medical care or items, dental or vision services, behavioral health services, long-term services and supports, and prescription drugs (but **not** Part D drugs). For example, use this section if:
    - o You are not getting medical care you want, and you believe our plan covers this care.

- We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
    - **NOTE:** Only use Section 5 for problems with drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with a DP are **not** covered by Part D. See Section 6 on page 169 for Part D drug appeals.
- You got medical care or services you think should be covered, but we are not paying for this care.
- You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
    - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 181 and 188.

- **Section 6 on page 169** gives you information if you have problems about Part D drugs. For example, use this section if:
    - You want to ask us to make an exception to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
    - You want to ask us to waive limits on the amount of the drug you can get.
    - You want to ask us to cover a drug that requires prior approval.
    - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
    - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- **Section 7 on page 181** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
    - You are in the hospital and think the doctor asked you to leave the hospital too soon.

- **Section 8 on page 188** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

If you need other help or information, please call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical care or items, dental or vision services, behavioral health services, and long-term services and supports. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with a DP are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the following situations:

1. **You think we cover a medical, behavioral health, or long-term care service you need but are not getting.**

   What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 154 for information on asking for a coverage decision.

2. **You want us to cover a benefit that requires plan approval (also called prior authorization) before you get the service.**

   What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 154 for information on asking for a coverage decision.

   NOTE: See the Benefits Chart in Chapter 4, Section D for a general list of covered services as well as information on what services require prior authorization from our plan. See the *List of Covered Drugs* to see if any drugs require prior authorization. You can also view the lists of services and drugs that require prior authorization at http://mmp.buckeyehealthplan.com.

3. **We did not approve care your doctor wants to give you, and you think we should have.**

   What you can do: You can appeal our decision to not approve the care. Go to Section 5.3 on page 157 for information on making an appeal.

4. **We did not approve your request to get waiver services from a specific network non-agency or participant-directed provider.**

   What you can do: You can appeal our decision to not approve the request. Go to section 5.3 on page 157 for information on making an appeal.

5. **You got services or items that you think we cover, but we will not pay.**

   What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 157 for information on making an appeal.

6. **You got and paid for services or items you thought were covered, and you want us to work with the provider to refund your payment.**

   What you can do: You can ask us to work with the provider to refund your payment. Go to Section 5.6 on page 167 for information on asking for payment.

7. **We reduced, suspended, or stopped your coverage for a certain service or item, and you disagree with our decision.**

   What you can do: You can appeal our decision to reduce, suspend, or stop the service or item. Go to Section 5.3 on page 157 for information on making an appeal.

   NOTE: If we tell you that previously approved services or items will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to get the services and items during the appeal. Read "*Will my benefits continue during Level 1 appeals"* on page 162.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 181 and 188 to find out more.

8. **We did not make a coverage decision within the timeframes we should have.**

   What you can do: You can file a complaint or an appeal. Go to Section 10 on page 196 for information on making a complaint. Go to Section 5.3 on page 157 for information on making a Level 1 Appeal.

   NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

9. **We did not make an appeal decision within the timeframes we should have.**

   What you can do: You can file a complaint. Go to Section 10 on page 196 for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you have not done so already. Go to Section 5.4 on page 162 for information on asking for a State

Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (go to Section 6 for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: 1-866-549-8289 TTY: 711
  Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- You can fax us at: 1-866-704-3064
- You can write to us at:

  Buckeye Health Plan – MyCare Ohio
  4349 Easton Way, Suite 400
  Columbus, OH 43219

➔ Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, see Section 2.1 on page 145.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid drugs within 72 hours after you asked.

We will make a standard coverage decision on all other services and items within 14 calendar days after you asked. If we don't give you our decision within 14 calendar days, you can appeal.

➔ You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 24 hours for Medicaid drugs and within 72 hours for all other services and items.

> ***The legal term*** *for "fast coverage decision" is* ***"expedited determination."***

➔ Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-866-549-8289 (TTY: 711) or fax us at 1-866-704-3064. For details on how to contact us, go to Chapter 2, page 14. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- You can also have your doctor or your authorized representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about refunding your payment for medical care or an item you already got.)
2. You can get a fast coverage decision *only* if the standard deadlines could *cause serious harm to your health or hurt your ability to function.* The standard deadlines are 72 hours for Medicaid drugs and 14 calendar days for all other services and items.

➔ **If your doctor says that you need a fast coverage decision, we will automatically give you one.**

➔ If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.

- If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines instead to make our decision.
- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section 10 on page 196.

If the coverage decision is Yes, when will I get the service or item?

For standard coverage decisions, we will authorize the coverage within 72 hours for Medicaid drugs and 14 calendar days for all other services and items. For fast coverage decisions, we will authorize the coverage within 24 hours for Medicaid drugs and 72 hours for all other services and items. If we extended the time needed to make our coverage decision, we will authorize the coverage by the end of that extended period.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).
- You also have the right to ask for a State Hearing if the coverage decision was for a service or item that could be covered by Medicaid (read Section 5.4 on page 162 for more information).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or other provider disagree with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. We will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

➔ **NOTE:** If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name him or her as your representative in writing. Read *"Can someone else make the appeal for me"* on page 149 for more information.

If you need help during the appeals process, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750). The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

➔ **NOTE:** You do not have to first appeal to the plan for services or items that are covered primarily by Medicaid or by both Medicare and Medicaid. You can appeal to the plan, the Bureau of State Hearings, or both. We will send you a notice of your right to appeal to the Bureau of State Hearings when the services or items are primarily covered by Medicaid or by both Medicare and Medicaid. Read below for information on filing an appeal with the plan, and go to Section 5.4 on page 162 for information on filing an appeal with the Bureau of State Hearings.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 90 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.

➔ Keep reading this section to learn about what deadline applies to your appeal.

How do I make a Level 1 Appeal?

o To start your appeal, you, your authorized representative, or your doctor or other provider must contact us. You can call us at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or write to us at the following address:

Buckeye Health Plan – MyCare Ohio
Attn: Appeals and Grievances -- Medicare Operations
7700 Forsyth Blvd
St. Louis, MO 63105

If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 202. Be sure to include your first and last name, the number from the front of your Buckeye Member ID Card, and your address and telephone number. You should also include any information that helps explain your problem.

- For additional details on how to reach us for appeals, see Chapter 2, Section A, page 14.
- You can ask us for a "standard appeal" or a "fast appeal."

> ***The legal term** for "fast appeal" is **"expedited reconsideration."***

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at http://mmp.buckeyehealthplan.com. We will also accept a letter or other appropriate form to authorize your representative.

➔ If the appeal comes from someone besides you or your doctor or other provider that requested the service, we must get your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf, we must get your written authorization.

How much time do I have to make an appeal?

You must ask for an appeal **within 90 calendar days** after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

➔ **NOTE:** If you appeal because we told you that a service you currently get will be changed or stopped, you have fewer days to appeal if you want to keep getting that

service while your appeal is processing. Read *"Will my benefits continue during Level 1 appeals"* on page 162 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 15 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time, or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 196.
- If we do not give you an answer to your appeal within 15 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (see Section 5.5 on page 164). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4 on page 162).

  You can also file a complaint about our failure to make an appeal decision within the required timeframe (see Section 10 on page 196).

➔ **If our answer is Yes** to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5 on page 164). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4 on page 162).

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 196.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (see Section 5.5 on page 164). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4 on page 162).

  You can also file a complaint about our failure to make an appeal decision within the required timeframe (see Section 10 on page 196).

➔ **If our answer is Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5 on page 164). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4 on page 162).

Will my benefits continue during Level 1 appeals?

Yes, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or other provider must **ask for an appeal on or before the later of the following** to continue the service during the appeal:

- Within 15 calendar days of the mailing date of our notice of action; or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) 15 calendar days pass after we notify you that we said **No** to your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **NOTE:** Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you also asked for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision (see Section 5.4 on page 162). If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process (see Section 5.5 on page 164).

Section 5.4: State Hearings for services primarily covered by Medicaid or both Medicare and Medicaid

You should read this section if you disagree with our coverage decision on a service or item that is primarily covered by Medicaid or both Medicare and Medicaid. You can request a State Hearing in addition to or instead of appealing to our plan.

What is a State Hearing?

A State Hearing is a meeting with you or your authorized representative, our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think our plan did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

We will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home &

Community-Based Services Waiver Member Handbook for more information about your rights.

How do I ask for a State Hearing?

To ask for a State Hearing, you or your authorized representative must contact the Bureau of State Hearings **within 90 calendar days** of receiving the notice of your State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. **Remember, you do not have to ask for a Level 1 Appeal before you can ask for a State Hearing.**

➔ **NOTE:** If you want someone to act on your behalf, including your doctor or other provider, you must give the Bureau of State Hearings written notice saying that you want that person to be your authorized representative.

You can sign and send the State Hearing form to the address or fax number listed on the form, or submit your request by e-mail to bsh@jfs.ohio.gov. You can also call the Bureau of State Hearings at 1-866-635-3748.

Can I get legal help for my State Hearing?

Yes. See Section 2.1 on page 145 for information on free legal help. Please remember, you do not need a lawyer to ask for a State Hearing.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the Bureau of State Hearings gets your request. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed but no later than 3 working days after the Bureau of State Hearings gets your request.

How will I find out about the decision?

The Bureau of State Hearings will send you a written hearing decision in the mail.

➔ If the hearing decision is **Yes (sustained)** to all or part of what you asked for, the decision will clearly explain what our plan must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.

➔ If the hearing decision is **No (overruled)** to part or all of what you asked for, it means the Bureau of State Hearings agreed with our plan. The State Hearing decision will explain

the Bureau of State Hearings' reasons for saying **No** and will tell you that you have the right to request an Administrative Appeal. The Bureau of State Hearings must get your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued. See Section 9.2 on page 195 for more information.

Will my benefits continue during my State Hearing?

Yes, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You or your authorized representative must **ask for a State Hearing before the later of the following** to continue the service during the State Hearing:

- Within 15 calendar days of the mailing date of our notice of action; or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the State Hearing request; 2) the Bureau of State Hearings decides **No** on your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **NOTE:** Sometimes your benefits may continue even if the Bureau of State Hearings says **No** to your appeal. If you also asked for an appeal with our plan, you may be able to continue your benefits until the plan makes its decision (see Section 5.3 on page 162). If the service is covered by both Medicare and Medicaid, your benefits will also continue during the Medicare Level 2 appeal process (see Section 5.5 on page 166).

Section 5.5: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medicaid** service or item, the letter will remind you that you may ask for a State Hearing if you have not done so already. Remember, you can ask

for a State Hearing in addition to or instead of appealing to our plan. See Section 5.4 on page 162 for information on State Hearings.

- If your problem is about a service or item that could be primarily covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will remind you that you may also ask for a State Hearing if you have not done so already. See Section 5.4 on page 162 for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item that is covered by Medicare or both Medicare and Medicaid. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

➔ The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

» However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➔ If you had “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

» However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

Will my benefits continue during Level 2 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, you can ask to continue your benefits during Medicare Level 2 appeals in some cases.

- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the Independent Review Entity (IRE).
- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will continue during the Level 2 appeal process with the IRE.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) the IRE decides **No** on your Level 2 Appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **NOTE:** If your problem is about a service primarily covered by both Medicare and Medicaid, sometimes your benefits may continue even if the IRE says **No** to your Medicare Level 2 Appeal. If you also asked for a Medicaid State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes its decision (see Section 5.4 on page 162).

How will I find out about the decision?

The Independent Review Entity (IRE) will send you a letter explaining its decision.

➔ If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.

➔ If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?

If either the Independent Review Entity or the Bureau of State Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the Independent Review Entity will explain additional appeal rights you may have.

See Section 9 on page 195 of this chapter for more information on additional levels of appeal.

Section 5.6: Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. If a provider bills you for any charges that we did not pay, that is called “balance billing.” You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

For more information, start by reading Chapter 7: *Asking us to pay a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will work with the provider to refund your payment.

  Or, if you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.

- If the service or item is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3 on page 157. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking to be paid back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

➔ If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

  - If the IRE reverses our decision and says we should make payment, we must send the payment to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to the provider within 60 calendar days.

  - If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page 195 for more information on additional levels of appeal.

➔ If we answer **No** to your appeal and the service or item is usually covered by Medicaid, you can request a State Hearing (see Section 5.4 on page 162).

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs with a DP. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with DP symbol follow the process in **Section 5** on page 152**.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).
  - **NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

> ***The legal term** for a coverage decision about your Part D drugs is **"coverage determination."***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to get your money back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** on page 170. Also see Sections 6.3 and 6.4 on pages 171 and 173.	**You can ask us for a coverage decision.** Skip ahead to **Section 6.4** on page 173.	**You can ask to have your money refunded.** (This is a type of coverage decision.) Skip ahead to **Section 6.4** on page 173.	**You can make an appeal.** (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** on page 176.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, page 92).
   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
     - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
     - » Quantity limits. For some drugs, we limit the amount of the drug you can have.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***“formulary exception.”***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say* Yes *or* No *to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 on page 176 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 2 on page 145 to find out how to give permission to someone else to act as your representative.

  ➔ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

***At a glance:* How to ask for a coverage decision about a Part D drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➔ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you paid for a drug that you think should be covered, read Chapter 7, Section A, page 110 of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.

    If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead. We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 196.

> ***The legal term*** *for "fast coverage decision" is* ***"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is Yes** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

> ***The legal term*** *for an appeal to the plan about a Part D drug coverage decision is plan* ***"redetermination."***

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

» If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 on page 174.

> ***The legal term*** *for "fast appeal" is* ***"expedited redetermination."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➔ **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."

- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➔ **If our answer is Yes** to part or all of what you asked for:

» If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

» If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said No and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will automatically send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➔ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."

- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the IRE approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE with the decision of your Level 2 appeal will tell you the dollar value needed to continue with the appeal process.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

➔ If you need help, please call Member Services or Medicare at the numbers listed above.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

In Ohio, the Quality Improvement Organization is called KEPRO. To make an appeal to change your discharge date, call KEPRO at: **1-855-408-8557 (TTY: 1-855-843-4776)**.

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 (TTY: 1-855-843-4776) and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

➔ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 186.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal** term for "fast review" is **"immediate review."***

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

***The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html*

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Ohio, the Quality Improvement Organization) is called KEPRO. You can reach KEPRO at: **1-855-408-8557 (TTY: 1-855-843-4776)**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

***At a glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 (TTY: 1-855-843-4776) and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 196 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: **How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only when they are covered by Medicare*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the *Notice of Medicare Non-Coverage*.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying the cost for your care.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 on page 196 tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. Or call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Ohio, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-855-408-8557 (TTY: 1-855-843-4776). Information about appealing to the Quality Improvement Organization is also in the *Notice of Medicare Non-Coverage.* This is the notice you got when you were told we would stop covering your care.

***At a glance:* How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization for your state at 1-855-408-8557 (TTY: 1-855-843-4776) and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page 192.

> ***The legal term*** *for the written notice is* ***"Notice of Medicare Non-Coverage."*** *To get a sample copy, call Member Services at 1-866-549-8289 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

In Ohio, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-855-408-8557 (TTY: 1-855-843-4776). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization for your state at 1-855-408-8557 (TTY: 1-855-843-4776) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

  If we say No to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

  » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➔ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term*** *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 196 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.

At a glance: **How to make a Level 2 Appeal to require that the plan continue your care**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

> ***The formal name*** *for "Independent Review Organization" is* ***"Independent Review Entity."*** *It is sometimes called the* ***"IRE."***

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Section 9.2: Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at 1-866-635-3748.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Buckeye staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

***At a glance:* How to make a complaint**

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section 10.2 on page 199.

➔ If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about receiving a bill

- Your doctor or provider sent you a bill.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

> ***The legal term*** *for a "complaint" is a* ***"grievance."***
>
> ***The legal term*** *for "making a complaint" is* ***"filing a grievance."***

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).**

Section 10.1: Internal complaints

To make an internal complaint, call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. Complaints related to Part D must be made **within 60 calendar days** after you had the problem you want to complain about. All other complaints must be made **within 90 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can also use the form on page 202 to submit the complaint. Send your complaint to:

  Buckeye Health Plan – MyCare Ohio
  Attn: Appeals and Grievances -- Medicare Operations
  7700 Forsyth Blvd
  St. Louis, MO 63105

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need to gather more information that may help you, we can take up to 14 more calendar days. If you believe we should not take extra days, you can file a "fast complaint." You can also file a fast complaint if we deny your request for a "fast coverage decision" or a "fast appeal." When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- The best way to file a fast complaint is by calling Member Services. Call 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.
- If you have a good reason for being late in filing a complaint, let us know and we will consider whether or not to extend the timeline for filing a complaint.

> ***The legal term*** *for "fast complaint" is* ***"expedited grievance."***

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint

about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 East Broad Street, 37th Floor
Columbus, Ohio 43215
1-866-227-6353 (TTY 1-866-221-6700)

You may also have rights under the Americans with Disability Act. You can contact Member Services at 1-866-549-8289 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day, or the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572) for assistance.

You can file a complaint with the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

In Ohio, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-855-408-8557 (TTY: 1-855-843-4776).

Section 10.3: Member complaint and appeal form

To file a complaint or appeal, call, write, or fax Buckeye. Or you can use the form on page 202 and fax or mail it to:

Buckeye Health Plan – MyCare Ohio
Attn: Appeals and Grievances -- Medicare Operations

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

7700 Forsyth Blvd
St. Louis, MO 63105

Phone: 1-866-549-8289 (TTY: 711)

Fax: 1-844-273-2671

You do not have to use this form to file a complaint or appeal. You can simply call Member Services to report a complaint or appeal. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan)

Member Complaint and Appeal Form

Member Name: _____

Medicare ID or Medicaid MMIS#: _____ Date of Birth: _____

Name of Person Submitting the Complaint or Appeal: _____

Phone Number(s): Home: _____ Cell: _____

Mailing Address: _____

City/State/Zip: _____

County: _____

If you are not the member, please state your relationship to the member* (choose one):
_____Parent _____Legal Guardian _____Spouse _____Physician
_____Other: _____

* If you are not the member, you must provide proof of guardianship, power of attorney, or an Appointment of Representative (AOR) form. The AOR form can be found on our website.

What is your complaint or appeal?

_____

_____

_____

_____

_____

_____

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Are you filing an expedited or fast appeal? _____YES _____NO

This means you feel using the standard deadlines could cause you serious harm to your life or health or jeopardize your ability to regain maximum function.

Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) will give you a decision within the following timeframes after receiving your request:

Standard Medical Pre-Service Appeals: 15 calendar days
Standard Prescription Drug Related Appeals: 7 calendar days
Expedited Medical Pre-Service Appeals: 72 hours
Expedited Prescription Drug Related Appeals: 72 hours

If we need more information and the delay is in your best interest or if you ask for more time, we have up to 14 more calendar days. We will tell you or your representative in writing if we decide to take extra days to make the decision.

If you are requesting an expedited or fast appeal, explain here why you need a fast appeal decision. You must also be asking for coverage for medical care or a drug you have not yet received.

_____

_____

_____

_____

If you are appealing the denial of a service or drug, what was denied? (Please include a copy of the denial letter.) Why do you think you should have this service, drug, or payment for the service or drug?

_____

_____

_____

_____

_____

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

How can Buckeye Health Plan - MyCare Ohio (Medicare-Medicaid Plan) resolve your issue?

_____

_____

_____

_____

_____

_____

Thank you for giving us the opportunity to resolve your complaint or appeal!

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

Chapter 10: Changing or ending your membership in our MyCare Ohio Plan

Table of Contents

Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan.

A. When can you change or end your membership in our MyCare Ohio plan?

You can ask to change or end your membership in Buckeye at any time.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request. Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you ask to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.
- If you ask to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

These are ways you can get more information about when you can change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

B. How do you change or end your membership in our plan?

If you decide to change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on pages 208-209.

See Section A, page 206 above for information on when your request to change or end your membership will take effect.

C. How do you join a different MyCare Ohio plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different MyCare Ohio plan.

To enroll in a different MyCare Ohio plan:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

If you make a request to switch to a different MyCare Ohio plan before the last five days of a month, your coverage with Buckeye will end on the last day of that same month. If you make a request to switch to a different MyCare Ohio plan on one of the last five days of a month, your coverage with Buckeye will end on the last day of the following month. See Section A, page 206 above for more information about when you can change or end your membership.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

D. If you do not want a different MyCare Ohio plan, how do you get Medicare and Medicaid services?

If you do not want to enroll in a different MyCare Ohio plan, you will go back to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by Buckeye.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: ▪ Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye when your new plan's coverage begins.

2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can select a Part D plan at this time. If you need help or more information: ▪ Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye when your Original Medicare and prescription drug plan coverage begins.
3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: ▪ Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye when your Original Medicare coverage begins.

How you will get Medicaid services

You must get your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you do not want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from Buckeye or another MyCare Ohio managed care plan.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care.

Once you stop getting Medicare services through our plan, you will get a new Member ID Card and a new *Member Handbook* for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

E. Until your membership changes or ends, you will keep getting your Medicare and Medicaid services through our plan

If you change or end your enrollment with Buckeye, it will take time before your new coverage begins. See page 206 for more information. During this time, you will keep getting your Medicare and Medicaid services through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.

If you are hospitalized on the day that your membership changes or ends, your hospital stay will be covered by our plan until you are discharged. This will happen even if your new health coverage begins before you are discharged.

F. Your membership will end in certain situations

These are the cases when Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

- If you move out of our service area.
- If you are away from our service area for more than six months or you establish primary residence outside of Ohio.
  - » If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.

You must be a United States citizen or lawfully present in the United States to be a member of our plan. The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis. We must disenroll you if you don't meet this requirement.

We can ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members.
- If you let someone else use your Member ID Card to get medical care.
  - » If your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

G. We *cannot* ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

You should also call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

If you have questions, please call Buckeye at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day. If you need to speak to your care manager, please call 1-866-549-8289 (TTY: 711), 24 hours a day, seven days a week. These calls are free. **For more information**, visit http://mmp.buckeyehealthplan.com.

H. You have the right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your membership. You can also see Chapter 9, Section 10, page 196 for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when Medicare and Medicaid can end your membership, you can call Member Services at 1-866-549-8289 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Chapter 11: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care. (Chapter 4, Section D.)

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal. (Chapter 9, Section 4.)

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. We do not allow providers to "balance bill" you. Because Buckeye pays the entire cost for your services, you should not get any bills from providers. Call Member Services if you get any bills that you do not understand. (Chapter 7, Section A.)

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies. (Chapter 5, Section B.)

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need. (Chapter 1, Section C.)

Care plan: A plan developed by you and your care manager that describes what medical, behavioral health, social, and functional needs you have and identifies goals and services to address those needs. (Chapter 1, Section G.)

Care team: A care team, led by a care manager, may include doctors, nurses, counselors, or other professionals who are there to help you build a care plan and ensure you get the care you need. (Chapter 1, Section C.)

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS. (Chapter 2, Section F.)

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. (Chapter 9, Section 10.)

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services. (Chapter 4, Section D.)

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision. (Chapter 9, Section 5.2.)

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan. (Chapter 5.)

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan. (Chapter 4.)

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). (Chapter 10.)

Durable medical equipment: Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds. (Chapter 4, Section D.)

Emergency: A medical condition that a prudent layperson with an average knowledge of health and medicine, would expect is so serious that if it does not get immediate medical attention it could result in death, serious dysfunction of a body organ or part, or harm to the function of a body part, or, with respect to a pregnant woman, place her or her unborn child's physical or mental health in serious jeopardy. Medical symptoms of an emergency include severe pain, difficulty breathing, or uncontrolled bleeding. (Chapter 4, Section D.)

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. (Chapter 3, Section H.)

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations. (Chapter 5, Section D.)

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS." (Chapter 6, Introduction.)

Fair hearing: A chance for you to tell your problem to a state representative and show that a decision we made is wrong. (Chapter 8, Section J.)

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug. (Chapter 5, Section B.)

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care. (Chapter 9, Section 10.)

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. They all work together to provide the care you need. (Chapter 1, Section C.)

Health assessment: A review of an enrollee's medical history and current condition. It is used to figure out the patient's health and how it might change in the future. (Chapter 1, Section F.)

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy. (Chapter 4, Section D.)

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. Buckeye must give you a list of hospice providers in your geographic area. (Chapter 4, Section D.)

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight. (Chapter 4, Section D.)

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary." (Chapter 1, Section J.)

Long-term services and supports (LTSS): Long-term services and supports include Long Term Care and Home and Community Based Service (HCBS) waivers. HCBS waivers can offer services that will help you stay in your home and community. (Chapter 3, Section E.)

Low-income subsidy (LIS): See "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section G, page 22 for information about how to contact Medicaid in your state. (Chapter 2, Section G.)

Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Ohio Medicaid coverage rules. (Chapter 3, Section B.)

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see “Health plan”). (Chapter 2, Section F.)

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B. (Chapter 4.)

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dual eligible beneficiary.”

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care. (Chapter 4.)

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services. (Chapter 4.)

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Buckeye includes Medicare Part D. (Chapter 5.)

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs. (Chapter 5.)

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state. (Chapter 1, Section E.)

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan. (Chapter 1.)

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, Section A, **Important Phone Numbers and Resources** for information about how to contact Member Services. (Chapter 2, Section A.)

Model of care: The structured and integrated approach Buckeye uses to deliver services and ensure care is appropriately coordinated among providers, pharmacies, and our care coordination team.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. (Chapter 1, Section J.)

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.” (Chapter 1, Section J.)

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital. (Chapter 4, Section D.)

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman’s services are free. (Chapter 2, Section H.)

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 explains how to ask us for a coverage decision. (Chapter 9, Section 1.2.)

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare. (Chapter 8, Section H.)

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply. (Chapter 5, Section A.)

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D, **Using the plan’s coverage for your health care and other covered services** explains out-of-network providers or facilities. (Chapter 3, Section D.)

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “Medicare Part D drugs.”

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3 for information about getting care from primary care providers. (Chapter 3, Section D.)

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the

Benefits Chart in Chapter 4**.** Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*. (Chapter 3, Section B.)

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy. (Chapter 4, Section D.)

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, Section E for information about how to contact the QIO for your state. (Chapter 2, Section E.)

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription. (Chapter 5, Section C.)

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 to learn more about rehabilitation services. (Chapter 4, Section D.)

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area. (Chapter 1, Section D.)

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services. (Chapter 4, Section D.)

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give. (Chapter 4, Section D.)

Specialist: A doctor who provides health care for a specific disease or part of the body. (Chapter 3, Section D.)

State Medicaid agency: The Ohio Department of Medicaid. (Chapter 2, Section G.)

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for. (Chapter 5, Section C.)

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Tier: A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them. (Chapter 3, Section H.)

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

Buckeye Health Plan:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Buckeye Health Plan's Member Services at 1-866-549-8289 TTY: 711.

If you believe that Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Buckeye Health Plan's Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800–368–1019, (TDD: 1-800–537–7697).

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

buckeye health plan

MyCareOhio
Connecting Medicare + Medicaid

Multi-language Interpreter Services

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-549-8289 (TTY: 711).

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-549-8289 (TTY: 711).

Chinese Mandarin:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-549-8289 (TTY: 711)。

Chinese Cantonese:
注意：如果您說英文，您可獲得免費的語言協助服務。請致電1-866-549-8289（聽障專線：711）。

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-549-8289 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0967-983-668, 1- (رقم هاتف الصم والبكم: 711).

Pennsylvania Dutch:
Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-549-8289 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-549-8289 (телетайп: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-549-8289 (ATS : 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-549-8289 (TTY: 711).

Cushite:
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-866-549-8289 (TTY: 711).

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-866-549-8289 (TTY: 711) 번으로 전화해 주십시오.

Italian:
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-549-8289 (TTY: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-866-549-8289 (TTY: 711)まで、お電話にてご連絡ください。

Dutch:
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-866-549-8289 (TTY: 711).

Ukraninian:
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-549-8289 (телетайп: 711).

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-866-549-8289 (TTY: 711).

Somali:
LA SOCO: Haddii aad ku hadasho Ingiriisi, adeegyada taageerada luqada, oo bilaash ah, ayaad heli kartaa, Wac 1-866-549-8289 (TTY: 711).

Nepali:
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ ।

फोन गर्नुहोस् 1-866-549-8289 (टिटिवाइ: 711) ।

buckeye health plan

Buckeye Health Plan Member Services

CALL: 1-866-549-8289

Calls to this number are free. Member Services hours are from <8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.>

Member Services also has free language interpreter services available for non-English speakers.

TTY: 711

Calls to this number are free. Member Services hours are from <8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you may be asked to leave a message. Your call will be returned within the next business day.>

WRITE: 4349 Easton Way
Suite 400
Columbus, OH 43219

WEB SITE: http://mmp.buckeyehealthplan.com