buckeye health plan™

+MyCareOhio
Connecting Medicare + Medicaid

Member Handbook

1-866-549-8289
TDD/TTY: 1-800-750-0750

mmp.BuckeyeHealthPlan.com

H0022_MMP14_022

NEW MEMBER INFORMATION

This handbook tells you about your coverage under Buckeye. It explains how to receive health care services, behavioral health coverage, prescription drug coverage, home and community based waiver services, also called long-term care services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. You will also find additional information such as: providers that you can use to receive care (also known as network providers); member rights; additional benefits; and steps you can take if you are unhappy or disagree with something.

Besides this member handbook, you should also receive a *Buckeye member ID card* and a *New Member Letter* with important information, including information about a Provider and Pharmacy Directory. Members enrolled in the MyCare Ohio waiver will also receive a supplement to their member handbook. This supplement provides additional information such as member rights and responsibilities, waiver service plan development, care management, waiver service coordination and reporting incidents. If you do not receive these items, please call Member Services for assistance.

While Buckeye is approved by the state and federal governments to provide both Medicare and Medicaid-covered services, you chose or were assigned to receive only your Medicaid-covered services from our plan.

If you want to receive both your Medicare and Medicaid-covered services from your MyCare Ohio MCP, see page 30 for more information.

You can also access Buckeye information on our website at mmp.BuckeyeHealth.com.
All members can communicate with Buckeye through the use of the website. Each inquiry will receive a response within one business day of receipt of the message through our website. This includes, but is not limited to, requests for member information such as ID cards, member handbooks, and provider directories.

Other services offered on the website include:

- News and events
- Provider search for doctors, specialists, and facilities
- Program information

This Member Handbook is effective **December, 2014**.

Important Phone Numbers

Emergency: 911 or local emergency number

Buckeye Member Services: 1-866-549-8289

NurseWise: 1-866-246-4358, option 7

Ohio Relay Service: TTY only: 1-800-750-0750

Member Services hours are 8:00 a.m. to 8:00 p.m. seven days a week, excluding holidays. Buckeye is closed on:

- New Year's Day
- Memorial Day
- Labor Day
- Christmas Day
- Martin Luther King Jr.'s Birthday
- Independence Day
- Thanksgiving Day

Buckeye will also be closed an additional two days throughout the year. We will notify our members about those office closings at least 30 days in advance of the closing.

A holiday that falls on a Saturday is observed on the Friday before it. One that falls on a Sunday is observed on the Monday after it.

PCP's Name: _____

PCP's Phone #: _____

PCP's After-Hours #: _____

Your Care Manager's Name: _____

Your Care Manager's Phone #: _____

Your Pharmacy: _____

Pharmacy's Phone #: _____

Your Dentist: _____

Dentist's Phone #: _____

Member Handbook

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Welcome

If you have any problem reading or understanding this or any other Buckeye Health Plan (a Medicare-Medicaid Plan) information, please contact our Member Services at 1-866-549-8289 (TTY 1-800-750-0750), 8am - 8pm seven days a week, for help at no cost to you.

Si tiene algún problema para leer o entender esto o cualquier otra información de Buckeye Health Plan (un Plan de Medicare-Medicaid), por favor comuníquese con nuestro departamento de Servicios para los Miembros para obtener ayuda sin ningún costo para usted al 1-866-549-8289 (TTY 1-800-750-0750), de 8 a. m. a 8 p. m., los siete días de la semana.

We can help to explain the information or provide the information orally, in English or 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.

Welcome to Buckeye Health Plan (Buckeye). You are now a member of a MyCare Ohio health care plan, also known as a MyCare Ohio managed care plan (MCP). A MCP 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 provides health care services to certain Ohio residents eligible for both Medicare and Medicaid benefits.

Buckeye may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.

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

Eligibility

WHO IS ELIGIBLE TO ENROLL IN A MYCARE OHIO PLAN?

You are eligible for membership in our MyCare Ohio plan as long as you:

- Live in our service area; **and**
- Have Medicare Parts A, B and D; **and**
- Have full Medicaid coverage; **and**
- Are 18 years of age or older at time of enrollment.

You are not eligible to enroll in a MyCare Ohio plan if you:

- Have a delayed Medicaid spend down.
- Have other third party creditable health care coverage except for Medicare.
- Have intellectual or other developmental disabilities and receive services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID).
- Are enrolled in PACE (Program for All-Inclusive Care for the Elderly).

Additionally, you have the option not to be a member of a MyCare Ohio plan if you:

- Are a member of a federally recognized Indian tribe;
- Have been determined by the County Board of Developmental Disabilities to qualify for their services; or
- Are 18 years of age and receiving foster care or adoption assistance under Title IV-E, in foster care or an out-of-home placement, or receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH).

If you believe that you meet any of the above criteria and should not be enrolled, please contact Member Services for assistance.

Buckeye is available only to people who live in our service area. Our service area includes Clark, Cuyahoga, Fulton, Geauga, Greene, Lake, Lorain, Lucas, Medina, Montgomery, Ottawa, and Wood. If you move to an area outside of our service area, you cannot stay in this plan. If you move, please report the move to your County Department of Job and Family Services office and Buckeye.

ID Cards

IDENTIFICATION (ID) CARDS

Your Buckeye membership ID card replaces your monthly Medicaid card. This card is good for as long as you are a member. You will not receive a new card each month as you did with the Medicaid card.

You must show your member ID card when you get any services or prescriptions covered by the plan. This means that you should show your new member ID card if you receive services from:

- your primary care provider (PCP)
- specialists and other providers
- dentists and vision providers
- emergency rooms or urgent care facilities
- hospitals for any reason
- medical suppliers
- pharmacies
- labs or imaging providers
- nursing or assisted living facilities
- waiver service providers

Call Member Services as soon as possible at 1-866-549-8289 if:

- you have not received your card(s) yet
- any of the information on the card(s) is wrong
- your card is damaged, lost or stolen
- you have a baby

You should always tell the provider that you also have Medicare coverage and they may want to see your red, white and blue Medicare card.

Providers

NETWORK PROVIDERS

It is important to understand that members must receive covered services from facilities and/or providers in Buckeye's provider network. A network provider is a provider who works with our health plan and except for pharmacy co-pays, has agreed to accept our payment as payment in full. Network providers include but are not limited to: doctors; certified nurse practitioners; pharmacies; clinics; hospitals, nursing facilities; home health agencies; medical equipment suppliers and others who provide goods and services that you get through Medicaid. The only time you can use providers that are not in network is for:

- Emergency services
- Federally qualified health centers/rural health clinics
- An out of network provider that Buckeye has approved you to see during or after your transition of care time period.
    - For a specified time period after your enrollment in the MyCare Ohio program, you are allowed to receive services from certain out-of-network providers and/or finish receiving services that were authorized by Ohio Medicaid. This is called your transition of care period. Please note, the transition periods start on the first day you are effective with any MyCare Ohio plan. If you change your MyCare Ohio plan, your transition period for coverage of a non-network provider does not start over. The enclosed *New Member Letter* has more information on transition time periods, services and providers. 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 immediately (today or as soon as possible) so we can arrange the services and avoid any billing issues.

You can find out which providers are in our network by calling member services at 1-866-549-8289 (TTY 1-800-750-0750) or on our website at BuckeyeHealthPlan.com. You can also contact the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1, or on the Medicaid Hotline website at www.ohiomh.com. You can request a printed Provider and Pharmacy Directory at any time by calling Member Services at 1-866-549-8289. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

PRIMARY CARE PROVIDERS

Each member of Buckeye must choose a primary care provider (PCP) from our provider network. Your PCP is an individual physician or physician group practice trained in family practice, internal medicine, general practice, OB/GYN, geriatrics, pediatrics, certified nurse practitioner, and physician assistant.

Your PCP will work with you to direct your health care. Your PCP will do your preventive care check-ups and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital.

- 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.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your Buckeye ID card.

Appointment Timeframe Standards

Buckeye contracts with providers to provide access within the following times:

- Routine appointments and physicals should be available within 28 days of request
- Primary care urgent appointments (non-life threatening) should be available within 6 hours of request
- Urgent care should be available within 24 hours.
- Urgent Specialty care within 24 hours of referral.
- Referrals to Specialist should be made within 4 weeks of request
- Emergency care should be received immediately and available 24 hours a day.
- Persistent symptoms must be treated no later than the end of the following working day after initial contact with the PCP.
- Referrals to a specialist should be scheduled within four (4) weeks of a request or shorter as medically indicated.
- Non urgent care – sick calls should be available within 72 hours of request.
- Prenatal Care patients should be seen within the following timeframes:
  - Three (3) weeks of a positive pregnancy test (home or laboratory)
  - Three (3) weeks of identification of high-risk
  - Seven (7) days of request in first and second trimester
  - Three (3) days of first request in third trimester
- Behavioral healthcare must be provided immediately for emergency services, within 24 hours of the request for urgent care, and within ten (10) days of the request for routine care.

If you are having trouble getting into a provider and need assistance, contact your Care Manager or Member Services.

Changing your PCP

If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. You can change your PCP monthly.

Sometimes your PCP may leave our provider network. If this happens, we will send you a letter letting you know and giving you information on a new PCP and/or how you can choose a new PCP.

Buckeye will send you a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP.

For the names of the PCPs in our network, you may look in your provider directory if you requested a printed copy, on our website at BuckeyeHealthPlan.com, or you can call member services at 1-866-549-8289 for help.

Member Services

MEMBER SERVICES

Member Services is available to help you with the following:

- Answer questions about covered Medicare and Medicaid benefits
- Help solve problems you may be having accessing health care or prescription drugs and answer questions about prescription copays
- Answer questions about services that require prior authorization
- Help find a provider
- File a complaint or appeal
- Change your PCP
- Access interpreter services
- Change your address
- Access 24-hour care management and behavioral health services

Call Member Services today for more information!

Member Services
1-866-549-8289
TTY 1-800-750-07650
8:00am-8:00pm, seven days a week

Care Management

CARE MANAGEMENT

Buckeye offers care management services to all members. When you first join our plan, you will receive a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. Nurses from our 24-hour NurseWise line and Care Managers conduct these assessments either by phone or in person. This assessment is important as it helps us work with you to understand what you want in terms of your physical, mental, and social well-being. It also helps us identify the right Care Manager to work with you on a one-to-one basis to meet your daily needs. Of course, you can always request to change your Care Manager by speaking with your Care Manager or calling Member Services.

After your health risk assessment, your care team will meet with you to talk about what services you need and want. Together, you and your care team will make a care plan. A ***care plan*** is the plan for what medical, behavioral, long term supports, social and functional services you will get and how you will get them. Every year (or more frequently depending on your needs), your care team will work with you to update your care plan when the services you need and want change.

If you are receiving Home and Community Based Waiver services, you will also have a ***service plan*****.** The service plan lists the services you will get and how often you will get them. This service plan will become part of your overall care plan.

Our care management program is designed to let us work with members to help them maintain good health and assist them and their doctor to arrange services that they may need to manage their health. The goal of our program is to learn what information or services members need in order to become more independent in meeting their healthcare needs.

Care Management Services

Buckeye offers care management services that are available to all members. Our care management program helps members learn more about their health concerns such as:

- Asthma
- Diabetes
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Non-mild hypertension (high blood pressure)
- Chronic obstructive pulmonary disease (COPD)
- Severe mental illness
- Severe cognitive and/or developmental limitation
- High-risk or high-cost substance abuse disorder
- Frequent admissions or ED room visits

Care Management Services While You Are In Transition

Make sure to let your Care Manager know if you are being admitted to a nursing facility or hospital or being discharged from a facility – especially if you are receiving care from hospital or emergency room that is not in Buckeyes' network. Your Care Manager will help make sure your care is coordinated between settings so that all of your providers have information about your medications and plan of care. We want to make sure tests and labs are done just once and that providers like your PCP know the results. Your doctors will always have your permission before sharing medical information with other providers.

When you are a patient in the hospital, if you are feeling well enough to have visitors, our nurses or social workers may come to your hospital room to visit you to discuss your discharge planning needs, answer any questions you may have about our benefits and services offered, and provide information to you about our care management program. Our staff will always check with the hospital staff first before entering your room to be sure that the timing is right for us to visit you.

Additionally:

- Buckeye staff, including nurses, care managers, and outreach workers may contact the member if a doctor has requested a phone call, if the member requests the phone call, or if Buckeye feels that care management services would be helpful to the member.
- Buckeye staff may ask the member questions to learn more information about his/her conditions(s).
- Buckeye staff will provide information to help a member understand how to care for his/her self and how to access services (including local resources).
- Buckeye staff will talk to the member's PCP and other service providers to coordinate care.
- Members should call Buckeye's Member Services department at 1-866-549-8289 (TTY 1-800-750-0750) if they have any questions about care management services or if they feel they would benefit from care management services.

Although Buckeye provides care management services for our members, we are aware that some members would prefer to not participate. For specifically identified members, Buckeye provides an "opt-out of care management" process. If you choose to not participate in our care management program, you can decline participation at any time by notifying your care manager.

Please call Buckeye's Member Services department at 1-866-549-8289 (TTY 1-800-750-0750) if you would like more information about our care management services. You can access care management services 24 hours a day by calling Member Services. After normal business hours, it is important to contact us if you have a change in care and need immediate assistance.

Covered Services

COVERED SERVICES

Medicaid helps with medical costs for certain people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and co-payments 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. Because you chose or were assigned to only receive Medicaid-covered services from our plan, Medicare will be the primary payer for most services. You can choose to receive both your Medicare and Medicaid benefits through Buckeye so all of your services can be coordinated. Please see page 30 for more information on how you can make this choice.

As a Buckeye member, you will continue to receive all medically-necessary Medicaid-covered services at no cost to you except for the prescription drugs that require a co-pay (see page 21).

- Ambulance and ambulette transportation*
- Assisted living services*
- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic (back) services
- Dental services (including oral surgery*)
- Diagnostic services (x-ray, lab)*
- Durable medical equipment and supplies*
- Emergency services
- Family planning services and supplies
- Free-standing birth center services at a free-standing birth center (members can call Member Services to see if there are any qualified, contracted centers in Ohio)
- Federally Qualified Health Center or Rural Health Clinic services
- Home health and private duty nursing services*
- Hospice care (care for terminally ill, e.g., cancer patients)*
- Inpatient hospital services*
- Medical supplies*
- Mental health and substance abuse services* (contact Member Services at 1-866-549-8289 or TTY 1-800-750-0750 24 hours a day, seven days a week for access to behavioral health crisis services)
- Nursing facility and long-term care services and supports*
- Obstetrical (maternity care - prenatal and postpartum including at risk pregnancy services) and gynecological services

- Outpatient hospital services*
- Physical and occupational therapy*
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Prescription drugs (certain drugs not covered by Medicare Part D)
- Preventative mammogram (breast) and cervical cancer (pap smear) exams
- Primary care provider services
- Renal dialysis (kidney disease)
- Screening and counseling for obesity
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services
- Speech and hearing services, including hearing aids*
- Therapy services (physical, occupational and speech)*
- Vision (optical) services, including eyeglasses (including surgery*)
- Waiver services*
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well adult exams

This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information, call Buckeye Member Services or read the Buckeye Member Handbook. Benefits, List of Covered Drugs, pharmacy and provider networks and copayments may change from time to time throughout the year and on January 1 of each year. Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.

*These services require ***prior authorization*** by the health plan – that means we need certain information from you, your provider, or waiver services coordinator to approve the service. If we do not approve a service, we will send you information on how you can appeal our decision and your right to a state hearing.

Contact your Care Manager or Member Services for more information.

Note: most services received by a provider who is not part of our network require prior authorization by Buckeye. Contact your Care Manager or Member Services for more information.

If you must travel 30 miles or more from your home to receive covered health care services, Buckeye will provide transportation to and from the provider's office. Please contact Member Services or your Care Manager for assistance.

In addition to the transportation assistance that Buckeye provides, members can still receive assistance with transportation for certain services through the local county department of job and family services **Non-Emergency Transportation (NET) program**. Call your county department of job and family services for questions or assistance with NET services.

NURSING FACILITY/LONG-TERM CARE SERVICES AND SUPPORTS

The Office of the State Long-Term Care Ombudsman helps people get information about long term care services in nursing homes and in your home or community, and resolve problems between providers and members or their families. They can help you file a complaint or an appeal with our plan in regard to your nursing home or long term care services and supports. You can call 1-800-282-1206 Monday through Friday 8:00 am to 5:00 pm. Calls to this number are free. You can submit an online complaint at: http://aging.ohio.gov/contact/ or you can send a letter to:

Ohio Department of Aging: LTC Ombudsman
50 W. Broad St./9th Floor
Columbus, OH 43215-3363

WAIVER SERVICES

MyCare Ohio Waiver services are designed to meet the needs of members 18 years or older, who are determined by the State of Ohio, or its designee, to meet an intermediate or skilled level of care. These services help individuals to live and function independently. If you are enrolled in a waiver, please see your MyCare Ohio Home & Community-Based Services Waiver member handbook for waiver services information.

HEALTHCHEK (WELL CHILD EXAMS)

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21 years. These exams are important to make sure that young adults are healthy and are developing physically and mentally. Members under the age of 21 years should have at least one exam per year.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental, and mental health exams, in addition to other care to treat physical, mental, or other problems or conditions found by an exam. Healthchek covers tests and treatment services that may not be covered for people over age 20; some of the tests and treatment services may require prior authorization.

Healthchek services are available at no cost to members and include:

- Preventive check-ups for young adults under the age of 21.
- Healthchek screenings:
  - Complete medical exams (with a review of physical and mental health development)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
- Laboratory tests for certain ages
- Immunizations
- Medically necessary follow up care to treat physical, mental, or other health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - visits with a primary care provider, specialist, dentist, optometrist and other Buckeye providers to diagnose and treat problems or issues
  - in-patient or outpatient hospital care
  - clinic visits
  - prescription drugs
  - laboratory tests
- Health education

Additionally, care management services are available to all members. Please see page(s) 11 to learn more about the care management services offered by our plan.

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Some services may require prior authorization by our plan. Also, for some EPSDT items or services, your provider may request prior authorization to cover services that have limits or are not covered for members over age 20.

You can obtain Healthchek services by calling your PCP's or dentist's office and scheduling an appointment. Make sure you tell them it is for Healthchek. If you would like more information about the Healthchek program, or if you need assistance with accessing care for covered services, making an appointment with a provider, getting transportation, or prior authorization, please contact Buckeye's Member Services department at 1-866-549-8289 (TTY 1-800-750-0750).

EMERGENCY SERVICES

Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor. We cover care for emergencies both in and out of the county where you live.

Some examples of when emergency services are needed include:
-Chest pain -Poisoning -Broken arm or leg -Severe bleeding -Severe burns
-Sudden shortness of breath or difficulty breathing
-Miscarriage/pregnancy with vaginal bleeding

You do not have to contact Buckeye for an okay before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate setting.

If you are not sure whether you need to go to the emergency room, call your primary care provider or NurseWise at 1-866-246-4358 (option 7). Your PCP or NurseWise can talk to you about your medical problem and give you advice on what you should do.

NurseWise
Phone: 1-866-246-4358 (option 7)

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of Buckeye and show them your ID card.
- If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency or to keep your condition stable, the provider must call our plan. The NurseWise number above can be accessed 24-7, seven days a week.
- Call your Buckeye PCP (or ask the hospital to call your PCP) as soon as possible. This lets your PCP know the care you received. Your PCP can then take over coordination of your care. You must contact your PCP within 24 hours to arrange follow-up care within the service area with participating providers.
- If the hospital has you stay, please make sure that our plan is called within 24 hours.

ADDITIONAL SERVICES/BENEFITS

Buckeye also offers the following extra services and/or benefits to their members.

NurseWise

NurseWise is a 24-hour, toll free phone line through which callers can reach both customer service representatives and bilingual nursing staff. The nurse triage service provides access to a broad range of health-related services including health education, urgent pharmacy re-fills, transportation for treatment, and crisis interventions.

The services listed below are available by contacting NurseWise at 1-866-246-4358 (TTY 1-800-750-0750):

- Medical advice line
- Health information library
- Help in determining where to go for care
- Answers to questions about your health
- Advice about a sick child
- Information about pregnancy
- Advice on how much medicine to give your child

Not sure if you need to go to the emergency room? Sometimes, you may not be sure if you need to go to the Emergency Room. Call NurseWise. They can help you decide where to go for care.

Over-The-Counter Benefit

Buckeye also overs $70 a quarter toward over-the-counter items from our mail order pharmacy. Members can have items such as vitamins, antacids, first aid supplies, oral care items, and pain relievers delivered free to their home.

For more information on any of these additional benefits we provide, please call Buckeye Member Services at 1-866-549-8289 (TTY 1-800-750-0750), 8am-8pm seven days a week.

NON-COVERED SERVICES

Buckeye will not pay for services or supplies received without following the directions in this handbook. We will not pay for the following services that are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- All services or supplies that are not medically necessary
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Paternity testing
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services to find cause of death (autopsy) or services related to forensic studies
- Services determined by Medicare or another third-party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure

This is not a complete list of the services that are not covered by Medicaid or our plan. If you have a question about whether a service is covered, please call the Member Services Department.

Medicaid Drug Coverage

PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE PART D

While most of your prescription drugs will be covered by Medicare Part D, there are a few drugs that are not covered by Medicare Part D but are covered by Buckeye. You can view our plan's *List of Covered Drugs* on our website at BuckeyeHealthPlan.com. Indicated drugs are not covered by Medicare Part D but are covered by Buckeye Medicaid.

You will have the following co-pays for Medicaid drugs covered by our plan:

Drug Tier	***Member Co-Pay***
Generic Medicaid-covered drugs	$1.20
Brand name Medicaid-covered drugs	$3.60

Note: Medicare-covered drugs must be obtained from Medicare. You can join Buckeye to receive all of your Medicare-covered services, including prescription drugs, from Buckeye. Contact Buckeye Member Services at 1-866-549-8289 for more information or the Ohio Medicaid Consumer Hotline at 1-800-324-8680 (www.ohiomh.com) to enroll.

If you think you are being charged the wrong copay, you should tell the pharmacy and you can get your prescription. You will still owe the pharmacy the co-pay and the pharmacy can refuse to provide future services for unpaid co-pays if they notify you in advance. Contact Member Services immediately-they can help resolve any concerns you have about your prescription copays. If you were charged the wrong copay, Member Services can arrange a refund from the pharmacy or health plan.

We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior authorize a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first.
- Some drugs may have quantity (amount) limits.

If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing. You can call member services to request information on medications that require prior authorization. You can also look on our website at BuckeyeHealthPlan.com. Please note that our list of medications that require prior authorization can change so it is important for you and/or your provider to check this information when you need to fill/refill a medication.

Member Rights

MEMBER RIGHTS

As a member of our health plan you have the following rights:

- To receive all services that our plan must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved 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.
- To be able to take part in decisions about your healthcare unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless we have to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or our plan must talk to you about what could happen and must put a note in your medical record about it.
- To be able to file an appeal**,** a grievance (complaint) or state hearing. See page25 of this handbook for information.
- To be able to get all MCP written member information from our plan:
  -at no cost to you;
  - in the prevalent non-English languages of members in the MCP's service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from our plan and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 37 which explains about advance directives.

- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another network PCP at least monthly. We must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the MCP, the MCP's providers or the Ohio Department of Medicaid will not hold this against you.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in our network for covered woman's health services.
- To be able to get a second opinion from a qualified provider in our network. If a qualified provider is not able to see you, we must set up a visit with a provider not in our network.
- To get information about (MCP Name) from us.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services' Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
(312) 886-2359 (312) 353-5693 TTY

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad St., 30th Floor
Columbus, Ohio 43215
(614) 644-2703 1-866-227-6353 1-866-221-6700 TTY
Fax: (614)752-6381

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 page 33.

Member Responsibilities

YOUR MEMBERSHIP RESPONSIBILITIES

As a member of Buckeye, you also have several responsibilities. They are to learn and understand each right you have under the Medicaid and Medicare programs. That includes the responsibility to:

- Ask questions if you don't understand your rights.
- Make any changes in your health plan and primary care provider in the ways established by the Medicaid and Medicare programs and Buckeye.
- Keep your scheduled appointments.
- Have ID card with you.
- Notify PCP of emergency room treatment.
- Cancel appointments in advance when you can't keep them.
- If Buckeye is providing transportation for you to a medical appointment, you must provide a car seat for any child riding with you if the child is 4 years of age or younger, or if the child weighs less than 40 pounds.
- Always contact your PCP or Buckeye's NurseWise first for your non-emergency medical needs.
- Only go to the emergency room when you think it is an emergency.
- To share information relating to your health status with your PCP and become fully informed about service and treatment options. That includes the responsibility to:
    - Tell your PCP about your health.
    - Talk to your providers about your healthcare needs and ask questions about the different ways your healthcare problems can be treated.
    - Help your providers get your medical records.
    - Actively participate in decisions relating to safe service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
        - Work as a team with your provider in deciding what healthcare is best for you.
        - Do the best you can to stay healthy.
        - Treat providers and staff with respect.

Complaints and Appeals

HOW TO LET BUCKEYE KNOW IF YOU ARE UNHAPPY OR DO NOT AGREE WITH A DECISION WE MADE

If you are unhappy with anything about our plan or its providers you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you authorize to speak for you, can contact us. If you want to authorize someone to speak for you, you will need to let us know. We want you to contact us so we can help you.

Complaints (also called grievances)

If you contact us because you are unhappy with something about our plan or one of our providers, this is called a grievance. For example, if you cannot get a timely appointment, if you think the provider office staff did not treat you fairly, or if you receive a bill you should contact us. You need to contact us within 90 calendar days from the day when you had the problem. We will give you an answer to your grievance by phone (or by mail if we can't reach you by phone) within the following time frames:

- 2 working days for grievances about not being able to get medical care.
- 30 calendar days for all other grievances not about being able to get medical care.

You also have the right at any time to file a complaint by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-324-8680

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
1-800-686-1526

Appeals

If you do not agree with certain decisions/actions made by our plan, and you contact us within 90 calendar days to ask that we change our decision/action, this is called an appeal. We will send you something in writing if we make a decision to:

- Deny, or only give partial approval for, a request to cover a service;
- Reduce, suspend or stop services that we had approved before you receive all of the services that were approved; or
- Deny payment for a service you received because it is not a covered benefit.

We will also send you something in writing if, by the date we should have, we did not:

- Make a decision on whether to cover a service requested for you, or
- Give you an answer to something you told us you were unhappy about.

If you do not agree with the decision/action listed in the letter, you can contact us to appeal. The 90 calendar day period begins on the day after the mailing date on the letter. Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. You, or your provider making the request on your behalf or supporting your request, can ask for a faster decision. This is called an expedited decision. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. If it is decided that your health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed, but no later than 72 hours after the request is received. If we deny the request to expedite the decision we will notify you in writing within two (2) calendar days.

If we made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services and when you may have to pay for the services.

How to contact our plan with a grievance or appeal

- Call the Member Services Department at 1-866-549-8289, or
- Fill out the form in your member handbook, or
- Call the Member Services Department to request they mail you a form, or
- Visit our website at BuckeyeHealthPlan.com, or
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your Buckeye member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

  Mail the form or your letter to:

Attention: Appeals and Grievances
Buckeye Health Plan – MyCare Ohio
4349 Easton Parkway, Suite 200
Columbus, Ohio 43219

Member Services
1-866-549-8289
TTY 1-800-750-0750

STATE HEARINGS

If you do not agree with certain decisions/actions made by our plan, you can also ask the state to change our decision/action by requesting a state hearing. A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from our plan and a hearing officer from the Ohio Department of Job and Family Services. We will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules.

We will notify you of your right to request a state hearing when a:

- Decision is made to deny, or only give partial approval for, a request to cover a service.
- Decision is made to reduce, suspend, or stop services that we previously approved before all of the approved services are received.
- Provider is billing you for services he/she provided. If you receive a bill, contact member services as soon as possible. We will first try and contact the provider to see if he/she will agree to stop billing.
    - 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 regarding waiver eligibility and services.

If you want a state hearing, you must request a hearing within 90 calendar days. The 90 calendar day period begins on the day after the mailing date on the hearing form. If we made a decision to reduce, suspend, or stop services before all of the approved services are received and you request the hearing within 15 calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first. You may have to pay for services you receive after the proposed date to reduce, suspend, or stop services if the hearing officer agrees with our decision.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. You or your authorized representative can ask for a faster decision, called an expedited decision. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. If the Bureau of State Hearings decides that your health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed, but no later than three (3) working days after the request is received.

How to request a state hearing
To request a hearing you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request via e-mail at bsh@jfs.ohio.gov. If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO).

ACCIDENTAL INJURY OR ILLNESS (SUBROGATION)
If you have to see a doctor for an injury or illness that was caused by another person or business, you must call the member services department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay the doctor's and/or hospital's bill. When you call we will need the name of the person at fault, their insurance company and the name(s) of any attorneys involved.

OTHER HEALTH INSURANCE (COORDINATION OF BENEFITS - COB)
We are aware that you also have health coverage through Medicare. If you have any other health insurance with another company, it is very important that you call the member services department and your county caseworker about the insurance. It is also important to call member services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

LOSS OF INSURANCE NOTICE (CERTIFICATE OF CREDITABLE COVERAGE)
Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company that says you no longer have insurance. It is important that you keep a copy of this notice for your records because you might be asked to provide a copy.

LOSS OF MEDICAID ELIGIBILITY
It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, our plan would be told to stop your membership as a Medicaid member and you would no longer be covered.

AUTOMATIC RENEWAL OF MCP MEMBERSHIP
If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically be re-enrolled in Buckeye.

Changing Your Membership

ENDING YOUR MCP MEMBERSHIP

You live in a MyCare Ohio mandatory enrollment area which means you must select a MyCare Ohio managed care plan unless you meet one of the exceptions listed on page 5. If your area would change to a voluntary enrollment area, the Ohio Department of Medicaid would notify you of the change.

Because you chose or were assigned to receive only have your Medicaid benefits through Buckeye, you can only end your membership at certain times during the year. You can choose to end your membership during the first three (3) months of your initial membership or during the annual open enrollment month. The Ohio Department of Medicaid will send you something in the mail to let you know when it is your annual open enrollment month. If you live in a MyCare Ohio mandatory enrollment area, you must choose another MyCare Ohio plan to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment month you can call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1. You can also submit a request on-line to the Medicaid Hotline website at www.ohiomh.com Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

Choosing A New Plan

If you are thinking about ending your membership to change to another health plan, you should learn about your choices. Especially if you want to keep your current provider(s). Remember, each health plan has a network of providers you must use. Each health plan also has written information which explains the benefits it offers and the rules you must follow. If you would like written information about a health plan you are thinking of joining or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1. You can also find information about the health plans in your area by visiting the Medicaid Hotline website at www.ohiomh.com

Choosing to receive both your Medicare and Medicaid benefits from a MyCare Ohio plan

You can request to receive both your Medicare and Medicaid benefits from Buckeye and allow us to serve as your single point of contact for all of your Medicare and Medicaid services. If you would like more information or to request this change you can contact the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1.

Ohio Medicaid Hotline
1-800-324-8680
www.ohiomh.com

Just Cause Membership Terminations

Sometimes there may be a special reason that you need to end your health plan membership. This is called a "Just Cause" membership termination. Before you can ask for a just cause membership termination you must first call your managed care plan and give them a chance to resolve the issue. If they cannot resolve the issue, you can ask for a just cause termination at any time if you have one of the following reasons:

1. You move and your current MCP is not available where you now live and you must receive non-emergency medical care in your new area before your MCP membership ends.
2. The MCP does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and all of the services aren't available on your MCP's panel.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCP's panel.
5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your MCP's panel and he/she was the only PCP on your MCP's panel that spoke your language and was located within a reasonable distance from you. Another health plan has a PCP on their panel that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. Other - If you think staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to end your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1. The Ohio Department of Medicaid will review your request to end your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use Buckeye doctors and other providers until the day you are a member of your new health plan, unless you are still in your transition period or live in a voluntary enrollment area and choose to return to regular Medicaid.
- If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan's Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1.
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or x-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Can Buckeye End My Membership?

Buckeye may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended.

The reasons that we can ask to end your membership are:

- For fraud or for misuse of your member ID card
- For disruptive or uncooperative behavior to the extent that it affects the MCP's ability to provide services to you or other members.

Buckeye provides services to our members because of a contract that our plan has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid you can call or write to:

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-324-8680 Monday through Friday 7:00 am to 8:00 pm
and Saturday 8:00 am to 5:00 pm
TTY users should call Ohio Relay at 7-1-1

You can also visit the Ohio Department of Medicaid on the web at: http://www.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 or income or other insurance.

You can contact Buckeye to get any other information you want including the structure and operation of our plan and how we pay our providers or if you have any suggestions on things we should change. Please call the member services department at 1-866-549-8289; (TTY 1-800-750-0750).

Privacy Notice

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.

Effective January 1, 2013
For help to translate or understand this, please call 1-866-549-8289.
Hearing impaired TTY 1-800-750-0750.
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono.
1-866-549-8289. (TTY 1-800-750-0750).
Interpreter services are provided free of charge to you.

At Buckeye Health Plan your privacy is important to us. We will do all we can to protect your health records. By law, we must protect your health records and send you this notice.

This notice tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to use those rights and who can see your health records. This notice does not apply to information that does not identify you.

When we talk about your health records in this notice, it includes any information about your past, present or future physical or mental health while you are a member of Buckeye Health Plan. This includes providing health care to you. It also includes payment for your health care while you are our member.

How We Use or Share Your Health Records
Here are ways we may use or share your health records:

- To help pay your medical bills given to us by health care providers.
- To help your health care providers give you the proper care. For example, if you are in the hospital, we may give them your records sent to us by your doctor.
- To help manage your health care. For example, we might talk to your doctor to suggest a disease or wellness program that could help improve your health.
- To help resolve any appeals or grievances filed by you or a health care provider with Buckeye Health Plan or the State of Ohio.
- To assist others who help us provide your health services. We will not share your records with these outside groups unless they agree to protect your records.
- For public health or disaster relief efforts.
- To remind you if you have a doctor's visit coming up.
- To give you information about other health care treatments and programs, such as information on how to stop smoking or lose weight.

State and federal laws may call for us to give your health records to others for the following reasons:

- To state and federal agencies that control us, such as the Ohio Department of Medicaid.
- For public health actions. For example, the Food and Drug Administration may need to check or track medicines and medical device problems.
- To public health groups if we believe there is a serious public health or safety threat.
- To a health agency for certain activities, such as audits, inspections, licensure and disciplinary actions.
- To a court or administrative agency.
- To law enforcement. For example, we may give your records to a law enforcement officer to identify or locate a suspect, fugitive, material witness or missing person.
- To a government person about child abuse, neglect or violence in your home.
- To a coroner or medical examiner to identify a dead person or help find a cause of death or to a funeral director to help them carry out their duties.
- For procurement, banking or transplantation of organs.
- For special government roles, such as military and veteran activities, national security and intelligence activities, and to help protect the President and others.
- Regarding job-related injuries due to your state's worker compensation laws.

If one of the above reasons does not apply, we must get your written approval to use or share your health records with others. If you change your mind, you may stop your written approval at any time.

What Are Your Rights?

The following are your rights about your health records. If you would like to use any of the following rights, please contact us. We can be reached at **1-866-549-8289**.

- ***You have the right to ask us to give your records only to certain people or groups and to say for what reasons.*** You also have the right to ask us to stop your records from being given to family members or others who are involved in your health care. Please note that while we will try to honor your wishes, the law does not make us do so.

- ***You have the right to ask to get confidential communications of your health records.*** For example, if you believe that you would be harmed if we send your records to your current mailing address, you can ask us to send your health records by other means. Other means might be fax or an alternate address.

- ***You have the right to view and obtain a copy of all the records we keep about you in your designated record set.*** This consists of anything we use to make decisions about your health. It includes enrollment, payment, claims processing and medical management records.

  You do not have the right to get certain types health records. We may decide not to give you the following:
  - Information contained in psychotherapy notes.
  - Information collected in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding.
  - Information subject to certain federal laws about biological products and clinical laboratories.

  In certain situations, we may not let you obtain a copy of your health records. You will be informed in writing. You may have the right to have our action reviewed.

- ***You have the right to ask us to make changes to wrong or incomplete health records we keep about you.*** These changes are known as amendments. We need you to ask for the change in writing. You need to give a reason for your change(s). We will get back to you in writing no later than 60 days after we receive your letter. If we need additional time, we may take up to another 30 days. We will inform you of any delays and the date when we will get back to you.

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

- ***You have the right to receive a list of certain times we have given your health records to others during the past six years.*** By law, we do not have to give you a list of the following:
  - Any health records collected prior to January 1, 2004.
  - Health records given or used for treatment, payment and health care operations purposes.
  - Health records given to you or others with your written approval.
  - Information that is incidental to a use or disclosure otherwise permitted.
  - Health records given to persons involved in your care or for other notification purposes.
  - Health records used for national security or intelligence purposes.

- Health records given to correctional institutions, law enforcement officials or health oversight agencies.
- Health records given or used as part of a limited data set for research, public health or health care operations purposes.

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

Using Your Rights

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

- ***If you have any questions about this notice or how we use or share your health records, please call.*** We can be reached at **1-866-549-8289**. That office is open seven days a week from 8 a.m. to 8 p.m.

If you believe your privacy rights have been violated, you may file a complaint in writing to:

Privacy Official
Buckeye Health Plan
Appeals/Grievance Coordinator
4349 Easton Way, Suite 200
Columbus, OH 43219
1-866-549-8289 (TTY 1-800-750-0750)

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

Office for Civil Rights - Region V
U.S. Department of Health & Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
1-312-886-2359 (TDD 1-312-353-5693)
1-312-886-1807 FAX
1-866-627-7748
www.hhs.gov/ocr

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

Advance Directives

Using Advance Directives to state wishes about your medical care.

Many people today 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 HAVE A CHOICE

A growing number of people are acting to make their wishes known. 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 down in writing.

This information explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care. This information also explains how you can state your wishes about the care you would want if you could not choose for yourself. This information does not contain legal advice, but will help you understand your rights under the law. For legal advice, you may want to talk to a lawyer. For information about free legal services, call 1-800-589-5888 Monday through Friday, 8:30 a.m. - 5 p.m.

What are my rights?

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

What if I'm too sick to decide? What if I can't 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're 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. You can use either a Living Will, a Declaration for Mental Health Treatment, a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order.

You fill out an advance directive while you're 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 don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

Do the people giving me medical care have to follow my wishes?
Yes, if your wishes follow state law. However, Ohio law includes a conscience clause. 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
This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your own wishes known. You can state when you would or would not want food and water supplied artificially.

How does a Living Will work?
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 can't 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 own wishes.

Only you can change or cancel your Living Will. You can do so at any time.

DO-NOT RESUSCITATE ORDER
State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identifies a person and specifies that CPR should not be administered to the person so identified. CPR means cardio-resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR.

The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a patient with a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken.

You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.

DURABLE POWER OF ATTORNEY

A Durable Power of Attorney for medical care is different from other types of powers of attorney. This brochure talks only about a Durable Power of Attorney for medical care, not about other types of powers of attorney.

A Durable Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while.

Who should I choose?

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

When does my Durable Power of Attorney for medical care take effect?

The form takes effect only when you can't choose your care for yourself, whether for a short or long while. This 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 a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

The Declaration for Mental Health Treatment supersedes a Durable Power of Attorney for mental health care, but does not supersede a Living Will.

ADVANCE DIRECTIVES

What is the difference between a Durable Power of Attorney for medical care and a Living Will?
Your Living Will explain, in writing, the type of medical care you would want if you couldn't make your wishes known. Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.

If I have a Durable Power of Attorney for medical care, do I need a Living Will, too?
You may want both. Each addresses different parts of your medical care.

Your Living Will makes your wishes known directly to your doctors, but states only your wishes about the use of life-support methods.

A Durable Power of Attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can't act for yourself. A Durable Power of Attorney for medical care does not supersede a Living Will.

Can I change my advance directive?
You, you can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio's law (effective October 10, 1991). You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. 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 can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also (see below).

OTHER MATTERS TO THINK ABOUT

What about stopping or not using artificially supplied food and water?
Artificially supplied food and water means nutrition supplied by way of tubes placed inside you. Whether you can decide to stop or not use them depends on your state of health.

- **IF** you are expected to die and can't make your wishes known
  AND your Living Will simply states you don't want life-support methods used to lengthen your life,
  THEN artificially supplied food and water can be stopped or not used.

- **IF** you are expected to die and can't make your wishes known,
  AND you don't have a Living Will
  THEN Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.

- **IF** you are in a coma that is not expected to end,
  AND your Living Will states you don't want artificially supplied food and water
  THEN artificially supplied food and water may be stopped or not used.

- **IF** you are in a coma that is not expected to end,
  AND you don't have a Living Will,
  THEN Ohio law allows your next-of-kin to stop or not use artificially supplied food and water. However, he or she must wait 12 months and get approval from a probate court.

By filling out an advance directive, am I taking part in euthanasia or assisted suicide?
No, Ohio law doesn't allow euthanasia or assisted suicide.

Where do I get advance directive forms?
Many of the people and places that give you medical care have advance directives forms. Ask the person who gave you this brochure for an advance directive form – either a Living Will, a Durable Power of Attorney for medical care, a DNR Order, or a Declaration for Mental Health Treatment. A lawyer could also help you.

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 Durable Power of Attorney for medical care, 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. Don't 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 any already difficult time. Some examples of organs that can be donated are 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:

- 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
- You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

This information is endorsed by the following organizations: Association of Ohio Philanthropic Homes and Housing for the Aging, Office of the Attorney General, State of Ohio, Ohio Academy of Nursing Homes, Ohio Council for Home Care, Ohio Department of Aging, Ohio Department of Health, Ohio Department of Job and Family Services, Ohio Department of Mental Health, Ohio Health Care Association, Ohio Hospice Organization, Ohio Hospital Association, Ohio State Bar Association, and Ohio State Medical Center.

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