Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) *Member Handbook*

January 1, 2023 – December 31, 2023

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

Member Handbook Introduction

This handbook tells you about your coverage under Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) (Buckeye Health Plan) through December 31, 2023. 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. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

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).

ATTENTION: If you speak a language other than English, language services, free of charge, are available to you. 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.

Si habla español, tiene servicios de asistencia de idiomas, sin cargo, disponibles para usted. Llame al 1-866-549-8289 (TTY: 711), de lunes a viernes, de 8 a.m. a 8 p.m. Es posible que fuera del horario de atención, los fines de semana y los días feriados le pidan que deje un mensaje. Lo llamaremos el siguiente día hábil. La llamada es gratuita.

You can get this document 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.

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

Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) wants to make sure you understand your health plan information. We can send future materials to you in Spanish or in alternate formats if you ask for it this way. This is called a “standing request.” We will document your choice.

Please call us if:

- You want to get your materials in Spanish or in an alternate format.
  or
- You want to change the language (English/Spanish) or format that we send you materials.

If you need help understanding your plan materials, please contact Buckeye Member Services 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.

2023 Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) *Member Handbook*

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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.

- Out-of-network/non-contracted providers are under no obligation to treat Buckeye Health Plan members, except in emergency situations. Please call our Member Services number or refer to your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.

- Coverage under Buckeye Health Plan is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Buckeye Health Plan, a health plan that covers all your Medicare and Medicaid services. It also tells you what to expect as a member and what other information you will get from Buckeye Health Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Welcome to Buckeye Health Plan

Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan), 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 Health Plan 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. Information about Medicare and Medicaid

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

B1. 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).

B2. 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,
- who qualifies,
- 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.

Medicare and Ohio Medicaid must approve Buckeye Health Plan 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 will not be affected.

C. Advantages of this plan

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

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

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- 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 Health Plan, and with your care providers to make sure you get the care you need. They 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. Buckeye Health Plan's service area

Buckeye Health Plan 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. Refer to Chapter 8, Section J, page 149 for more information about the effects of moving out of our service area.

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 (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it); **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 Health Plan 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 choice to disenroll from Buckeye Health Plan if you are a member of a federally recognized Indian tribe.

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

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 Health Plan. Your care manager may also schedule you for a visit with your primary care provider (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 Health Plan does not normally cover, you can get a transition supply. We will also help you get another drug or get an exception for Buckeye Health Plan to cover your drug, if medically necessary.

If Buckeye Health Plan is new for you, you can keep using the doctors you use 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 use doctors and other providers in the Buckeye Health Plan network for most services. A network provider is a provider who works with the health plan. Refer to Chapter 3, Section D, page 31 for more information on getting care. Member Services can help you find a network provider.

If you are currently using 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. Your care plan

Your 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 your 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. Buckeye Health Plan monthly plan premium

Buckeye Health Plan does not have a monthly plan premium.

I. 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, refer to Chapter 9, Section D, page 159. You can also call Member Services at 1-866-549-8289 (TTY: 711) or Medicare at 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* 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 refer to the *Member Handbook* at mmp.buckeyehealthplan.com or download it from this website.

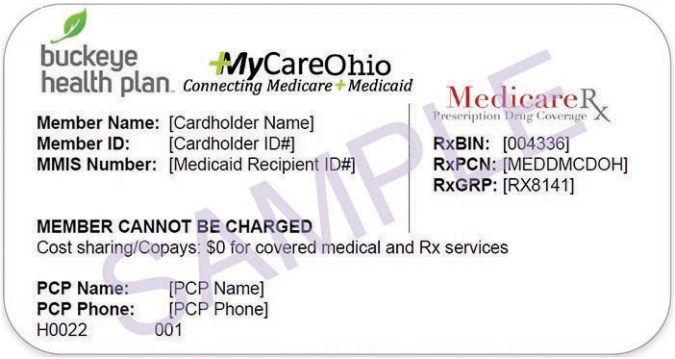
The contract is in effect for months in which you are enrolled in Buckeye Health Plan between January 1, 2023 and December 31, 2023.

J. Other important information you will get from us

You will also get a Buckeye Health Plan Member ID Card, a New Member Letter with important information, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*. 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.

J1. Your Buckeye Health Plan 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:


buckeye health plan MyCareOhio Connecting Medicare + Medicaid

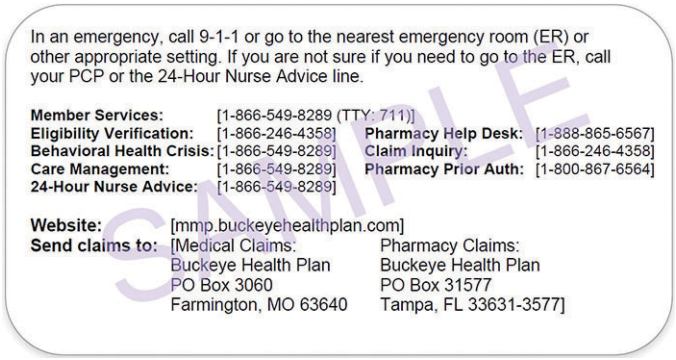
Member Name: [Cardholder Name]
Member ID: [Cardholder ID#]
MMIS Number: [Medicaid Recipient ID#]

MedicareRx Prescription Drug Coverage
RxBIN: [004336]
RxPCN: [MEDDMCDOH]
RxGRP: [RX8141]

MEMBER CANNOT BE CHARGED
Cost sharing/Copays: $0 for covered medical and Rx services

PCP Name: [PCP Name]
PCP Phone: [PCP Phone]
H0022 001

SAMPLE


In an emergency, call 9-1-1 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 Nurse Advice line.

Member Services: [1-866-549-8289 (TTY: 711)]
Eligibility Verification: [1-866-246-4358]
Behavioral Health Crisis: [1-866-549-8289]
Care Management: [1-866-549-8289]
24-Hour Nurse Advice: [1-866-549-8289]
Pharmacy Help Desk: [1-888-865-6567]
Claim Inquiry: [1-866-246-4358]
Pharmacy Prior Auth: [1-800-867-6564]

Website: [mmp.buckeyehealthplan.com]
Send claims to: [Medical Claims: Buckeye Health Plan PO Box 3060 Farmington, MO 63640
Pharmacy Claims: Buckeye Health Plan PO Box 31577 Tampa, FL 33631-3577]

SAMPLE

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. If you show your Medicare card instead of your Buckeye Health Plan Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A, page 122 to find out what to do if you get a bill from a provider.

J2. 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.

J3. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Buckeye Health Plan 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 (refer to page 10) and for certain services (refer to Chapter 3, Section A, page 29).

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 refer to the *Provider and Pharmacy Directory* at 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.

Definition of network providers

- Buckeye Health Plan's network providers include:

- Doctors, nurses, and other health care professionals that you can use as a member of our plan;
- Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
- 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, refer to 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, refer to Chapter 7, Section A, page 122.

Definition of 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.

J4. *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 Health Plan.

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. Refer to Chapter 5, Section C, page 104 for more information on these rules and restrictions.

Each year, we will send you information about how to access 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 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.

J5. *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.

J6. The *Explanation of Benefits*

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

The EOB tells you the total amount we, or others on your behalf, have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. Chapter 6, Section A, page 116 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your membership record up to date

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

- The Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 1-800-292-3572.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation

- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).
- If you have to use 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 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.

K1. Privacy of your personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section D, page 132.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Buckeye Health Plan, the State of Ohio, Medicare, and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact Buckeye Health Plan 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 120 Columbus, OH 43219 If you are sending us an appeal or complaint, you can use the form in Chapter 9, page 208. You can also write a letter telling us about your question, problem, complaint, or appeal.
WEBSITE	mmp.buckeyehealthplan.com

A1. When to contact Member Services:

- 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

  - 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 Health Plan, 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 Health Plan
  - You can ask for more information about our plan, including information regarding the structure and operation of Buckeye Health Plan 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, refer to Chapter 9, Section D, page 159.
- 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, refer to Chapter 9, Section D, page 159.
- 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 (refer to Section E below, page 23).

- If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (refer to the section above page 18).
- You can send a complaint about Buckeye Health Plan right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can send a complaint about Buckeye Health Plan directly to Ohio Medicaid. Call 1-800-324-8680. This call is free. Refer to page 25 for other ways to contact Ohio Medicaid.
- You can send a complaint about Buckeye Health Plan to the MyCare Ohio Ombudsman. Call 1-800-282-1206. This call is free.
- To learn more about making a complaint, refer to Chapter 9, Section J, page 202.

- 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, refer to Chapter 7, Section A, page 122.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section E5, page 176 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 120 Columbus, OH 43219
WEBSITE	mmp.buckeyehealthplan.com

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

The Nurse Advice Call Line is a valuable resource provided to Buckeye Health Plan 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 the Nurse Advice Call Line are free.

CALL	1-866-549-8289 This call is free. The Nurse Advice Call 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 Nurse Advice Call Line is available 24 hours a day, 7 days a week, 365 days a year.

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

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.

D1. When to contact the Behavioral Health Crisis Line

- Questions about behavioral health services

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

An organization called Livanta 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. Livanta is not connected with our plan.

CALL	1-888-524-9900
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

E1. When to contact Livanta

- 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,
    - think your hospital stay is ending too soon, **or**
    - 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	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, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

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 Health Plan 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm.
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 am to 8:00 pm, and Saturday from 8:00 am to 5:00 pm.
WRITE	Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215
EMAIL	bmhc@medicaid.ohio.gov
WEBSITE	www.medicaid.ohio.gov/provider/ManagedCare

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: jfs.ohio.gov/County/County_Directory.pdf.

H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MyCare Ohio Ombudsman also 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 not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-800-282-1206 This call is free. The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 am to 5:00 pm.
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	www.aging.ohio.gov/wps/portal/gov/aging/care-and-living/get-help/get-an-advocate/my-care-ohio-ombudsman You can submit an online complaint at: aging.ohio.gov/Contact.

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Buckeye Health Plan. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information 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 50.

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 use 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. Refer to Chapter 4, Section C, page 48 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. Refer to Chapter 6, Section C3, page 118 for more information.

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

Buckeye Health Plan covers health care services covered by Medicare and Medicaid. This includes behavioral health and long-term services and supports.

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

- The care you get must be a **plan benefit**. Refer to Chapter 4, Section D, page 50 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, equipment or drugs meet accepted standards of medical practice.

- The care you get must be prior authorized by Buckeye Health Plan when required. For some services, your provider must submit information to Buckeye Health Plan and ask for approval for you to get the service. This is called prior authorization (PA). Refer to the chart in Chapter 4, Section D, page 50 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 use other providers, it is still important to contact your PCP before you use 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, refer to page 33.
- **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 find out what emergency or urgently needed care means, refer to Section I, page 40.
    - 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 use an out-of-network provider, refer to Section D, page 31.
    - 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 or when your provider for this service is unavailable or inaccessible 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 use your current out-of-network providers for a period of time after you enroll. This is called a "transition period." For more information, refer to Chapter 1, Section F, page 10 of this handbook and your New Member Letter.

C. Information about your care team and care manager

Your care team includes a care manager from Buckeye Health Plan 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. They work with your care team to make sure you get the care you need. They will work with you, your family, community support(s) and your doctor(s) to develop a plan of care and help you find community resources for services not covered by Buckeye Health Plan.

C1. What care management is

Care management is a program used at Buckeye Health Plan to coordinate care for our members.

C2. How you can contact your care manager

You can contact your care manager by calling 1-866-549-8289 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year.

C3. How you will interact with your care manager and care team

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.

C4. How you can 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. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

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

Definition of "PCP" and what a PCP does

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
- Obstetrician-gynecologist (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 D, page 132 tells you how we will protect the privacy of your medical records and personal health information.

Once you are enrolled in Buckeye Health Plan, 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 PCP 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 Health Plan. 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.

Your choice of PCP

You can choose any network PCP listed in the *Provider and Pharmacy Directory*. Please review our *Provider and 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.

Option to change 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 our 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 effectivethe 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.

D2. 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 prior authorization directly from Buckeye Health Plan. For information about which services require prior authorization, see the benefits chart in Chapter 4, Section D, page 50 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.

D3. What to do when a 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.
- We will make a good faith effort to 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 we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- 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 make a complaint. Refer to Chapter 9 for information about making an appeal.

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.

D4. 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 Health Plan.

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 Health Plan'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.

If you use 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 use 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 services and supports are available to all Buckeye Health Plan members who meet eligibility requirements. To get long-term supports and services, you can contact your care manager, waiver services manager, or PCP. A long-term supports and services (waiver) manager 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) manager from in-network providers.

If you are already receiving long-term services and supports, your Buckeye Health Plan 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 Health Plan 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, refer to the benefits chart in Chapter 4, Section D, page 50 of this handbook. To get other behavioral health services, please contact your care manager or PCP.

G. How to get transportation services

G1. How to get transportation services

- Telephone number to arrange
    - Call Member Services at 1-866-549-8289 (TTY: 711) to schedule transportation. While normal business hours are from 8 a.m. to 8 p.m., Monday through Friday, we always have limited staff available after hours and on weekends/holidays to help members schedule emergency transportation needs.
- Advance notification requirements
    - Non-emergency transportation requests should be placed 48 hours (two business days) in advance.
- Transportation Coverage
    - Buckeye Health Plan offers unlimited transportation to all members (men, women, and children) for all transportation needs covered under our benefit plan.
    - A sample of trips covered under our benefit plan include medical appointments, trips to the pharmacy, and several "non-medical" trip types such as redetermination appointments, job interviews, and trips to the Housing Authority. In addition, we offer every member ten one-way trips per year to food banks and/or grocery stores.
    - If you have to travel 30 miles or more from your home to get covered health care services, Buckeye Health Plan will provide transportation to and from the provider's office.
- Waiver Transportation
    - For information specific to waiver transportation services, call your waiver service manager.

In addition to the transportation assistance that Buckeye Health Plan 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.

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

H1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or, if pregnant, to that of your unborn child; **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, when:
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to 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 Health Plan. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- Be sure to tell the provider that you are a Buckeye Health Plan member. Show the provider your Buckeye Health Plan 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 Health Plan 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, 7 days a week, 365 days a year.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D, page 50.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

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, 7 days a week, 365 days a year. 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. Our plan covers your follow-up care. 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.

What to do if you have a behavioral health emergency

Definition of a behavioral health emergency

A behavioral health emergency is when a mental health condition with symptoms such as hallucinations, delusions, or mood changes put you or someone else at risk for serious harm. The condition is so serious that, if it does not get immediate treatment, the symptoms could lead to any of the following results:

- A suicide attempt or serious self-harm;
- An attempt to harm someone else;
- The loss of your ability to care for yourself or to keep yourself safe;
- A custody order to be detained in a psychiatric hospital.

If you are having a behavioral health emergency, please call the Buckeye Health Plan Behavioral Health Crisis line at 1-866-549-8289 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year. You can also call your Care Manager, Behavioral Health Care Manager or Local Mental Health Authority (LMHA) Crisis Line. Contact your Care Manager or Behavioral Health Care Manager for more information.

If you are having a life-threatening medical emergency, please call 911.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn't really an 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 use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

H2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

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 it is not possible or reasonable to 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 mmp.buckeyehealthplan.com.

If you are not sure whether you have an emergency or require urgent care, please contact Member Services at 1-866-549-8289 (TTY: 711), to be connected to the Nurse Advice Call Line services. As a Buckeye Health Plan Member, you have access to triage or screening services, 24 hours a day, 7 days a week, 365 days a year.

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

When you are outside the plan's 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.

H3. 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 Health Plan.

Please visit our website for information on how to obtain needed care during a declared disaster: 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 refer to Chapter 5, Section A8, page 101 for more information.

I. What to do if you are billed directly for 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, **refer to Chapter 7**, **Section A, page 122 to learn what to do**.

I1. What to do if services are not covered by our plan

Buckeye Health Plan covers all services:

- that are medically necessary, **and**

- that are listed in the plan's Benefits Chart (refer to Chapter 4, Section D, page 50), **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 D, page 159 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 PA from Buckeye Health Plan 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. Coverage of health care services covered when you are in a clinical research study

J1. Definition of 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. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out 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 any Medicare-approved clinical research study, you do not need to tell us or 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.

Ohio Medicaid does not cover clinical research studies.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your care manager should contact Member Services to let us know you will be in a clinical trial.

J2. Payment for services when you are in a clinical research study

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.

J3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.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 your health care services are covered when you get care in a religious non-medical health care institution

K1. Definition of 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.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Getting care from a religious non-medical health care institution

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 refer to the Benefits Chart in Chapter 4, Section D, page 50 for more information.

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Buckeye Health Plan, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

Even if you had the DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 11. You can also find more information about them in the *Medicare & You 2023* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME 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 or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or Medicare Advantage plan.

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Buckeye Health Plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you what services Buckeye Health Plan 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, Section A, page 98, and information about what you pay for drugs is in Chapter 6, Section C3, page 118.

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. Refer to Chapter 3, Section B, page 29 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, 7 days a week, 365 days a year.

A1. During public health emergencies

Buckeye Health Plan will follow any and all state and/or federal guidance related to a public health emergency (PHE). During a PHE, the plan will provide all necessary coverage for our members. The coverage may vary depending on the services received and the duration of the PHE. Please visit our website for more information on how to obtain needed care during a PHE at mmp.buckeyehealthplan.com or call the Nurse Advice Call Line. You can reach the Nurse Advice Call Line at 1-866-549-8289 (TTY: 711), 24 hours a day, 7 days a week, 365 days a year.

Buckeye Health Plan will cover all COVID-19 testing, treatment, and vaccinations without copays.

COVID-19 Testing

You can find COVID-19 testing locations online at coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.

COVID-19 Vaccinations

The Ohio Department of Health (ODH) has a search tool you can use to find a vaccine provider. You can search the directory by county and ZIP code. It displays providers currently getting shipments of COVID-19 vaccines. You can get information and vaccination locations at vaccine.coronavirus.ohio.gov/ or by calling ODH toll-free at 833-427-5634.

Buckeye Health Plan can help you find a testing or vaccination location in your community. They also can help with scheduling and transportation to your appointment. Use the information at the bottom of the page to contact Buckeye Health Plan Member Services or the Nurse Advice Hotline at 1-866-549-8289 (TTY: 711). The Nurse Advice Call Line is available 24 hours a day, 7 days a week, 365 days a year.

ODH gives regular updates on vaccination eligibility phases at coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program.

B. Rules against providers charging you for services

Except as indicated above, we do not allow Buckeye Health Plan 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, refer to Chapter 7 or call Member Services.

C. Our plan's Benefits Chart

The following Benefits Chart in Section D 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.

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 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.
    - If Buckeye Health Plan 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, refer to Chapter 9, Section D, page 159.
- 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 31 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 (PA). 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 PA, contact Member Services or visit our website at 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

D1. Preventive 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

D2. Preventive 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.	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 each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • 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 119 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 ages 50-77, **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 20 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
Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	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

Services covered by our plan	Limitations and exceptions
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

D3. Other Services

Services covered by our plan	Limitations and exceptions
Acupuncture The plan covers acupuncture for pain management of headaches, lower back pain, neck pain, osteoarthritis of the hip or knee, nausea or vomiting related to pregnancy or chemotherapy, and acute post-operative pain. The plan will also pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments each year for chronic low back pain. Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.	Authorization is required for more than 30 acupuncture visits per benefit year. **Prior authorization (approval in advance) may be required. Please contact the plan for details.**
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.	**Prior authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Chiropractic services The plan covers: • Diagnostic x-rays • Adjustments of the spine to correct alignment	None
Dental services The plan covers the following services: • 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, sealants, and space maintainers • Routine radiographs/diagnostic imaging • Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services • Extractions	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.
 	
Diabetic glucometer and supplies are limited to OneTouch when obtained at a pharmacy. Other brands are not covered unless pre-authorized.
	Prior authorization (approval in advance) may be required. Please contact the plan for details.

Services covered by our plan	Limitations and exceptions
Durable medical equipment (DME) and related supplies Covered DME includes, but is not limited to, the following: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers Other items (such as incontinence garments, enteral nutritional products, ostomy and urological supplies, and surgical dressings and related supplies) may be covered. For additional types of supplies that the plan covers, refer to 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 DME 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 (also refer to "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 if pregnant, to that of your unborn child; **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, when:
  ○ there is not enough time to safely transfer you to another hospital before delivery.
  ○ a transfer to another hospital 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), HIV/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 specialist 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.**
Health and wellness education programs **Remote Access Technology (Web/Phone based technologies)** The plan offers an online member portal that provides additional features and information outside of the plan's website. **Nurse Advice Call Line** Medical Advice, Behavioral Health Crisis, Care Management Support and Nurse Advice Call Line services through toll-free 24 hours a day, 7 days a week, 365 days a year call-in systems that are available nationwide. **Fitness Benefit** The fitness benefit provides a basic fitness membership at participating facilities.	None

Services covered by our plan	Limitations and exceptions
Hearing services and supplies The plan covers the following: • 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) ○ Conventional hearing aids are covered once every 4 years ○ Digital/programmable hearing aids are covered once every 5 years ○ 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 • Enhanced community living services • Home care attendant • Home delivered meals • Home medical equipment and supplemental adaptive and assistive device services • Home modification, maintenance, and repair • Homemaker services • Independent living assistance **This benefit is continued on the next page**	**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. Community Transition services are limited to $2,000 per waiver enrollment period.

Services covered by our plan	Limitations and exceptions
Home and community-based waiver services (continued) • Nutritional consultation • Out-of-home respite services • Personal care aide services • Personal emergency response services • Pest control • Social work counseling • Waiver nursing services • Waiver transportation	Home Medical Equipment & Supplemental Adaptive & Assistive Devices: Device Services shall not exceed a combined total of $10,000 within a calendar year per individual. Home Modification is limited to $10,000 per twelve- month calendar year. Home Maintenance and Chore Services: Services shall not exceed a total of $10,000 in a calendar year per individual.

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) • 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.** Additional hours over the State Medicaid Plan services of 14 hours per week require prior authorization.

Services covered by our plan	Limitations and exceptions
Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	**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 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. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. 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:** • Refer to Section F of this chapter for more information. **For services covered by Buckeye Health Plan but not covered by Medicare Part A or B:** • Buckeye Health Plan 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 Health Plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. **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, 7 days a week, 365 days a year. 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 use disorder 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 outside the pattern of care for your community. If Buckeye Health Plan provides transplant services at a distant location outside the pattern of care for your community 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 Health Plan.	
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If your inpatient stay is not reasonable and necessary, 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 **This benefit is continued on the next page**	None

Services covered by our plan	Limitations and exceptions

Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)
• 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	

Services covered by our plan	Limitations and exceptions
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 29, or when your provider for this service is temporarily unavailable or inaccessible • 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 refer to “Medicare Part B prescription drugs” in this chart.	None
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.	None

Services covered by our plan	Limitations and exceptions
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Buckeye Health Plan 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 necessary), 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 **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
Medicare Part B prescription drugs (continued) The following link will take you to a list of Part B drugs that may be subject to step therapy: mmp.buckeyehealthplan.com/mmp/resources.html. We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5, Section A, page 98 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6, Section C3, page 118 explains what you pay for your outpatient prescription drugs through our plan.	
Mental health and substance use disorder services at addiction treatment centers The plan covers the following services at addiction treatment centers: • Ambulatory detoxification • Assessment • Case management • Counseling • Crisis intervention • Intensive outpatient • Alcohol/drug screening analysis/lab urinalysis • Medical/somatic • Methadone administration • Office administered medications for addiction including vivitrol and buprenorphine induction Refer to “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 use disorder treatment services at community mental health centers The plan covers the following services at certified community mental health centers: • Mental health assessment/diagnostic psychiatric evaluation • Assertive Community Treatment (ACT) • Intensive Home Based Treatment (IHBT) • Screening, Brief Intervention and Referral to Treatment (SBIRT) • Psychological Testing • Therapeutic Behavioral Services (TBS) • Psychosocial Rehabilitation • Community psychiatric supportive treatment (CPST) services • Counseling and therapy • Crisis intervention • Pharmacological management • Certain office administered injectable antipsychotic medications • Partial hospitalization for Substance Use Disorder only Partial hospitalization is a structured program of active substance use disorder treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. Refer to "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 (SNF) 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 necessary • 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 **This benefit is continued on the next page**	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. **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 (SNF) care (continued) 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 Health Plan member 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 or domestic partner lives at the time you leave the hospital**	
Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing)	None

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 • Therapeutic Behavioral Services (TBS) • Psychosocial rehab services	None

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 outpatient surgery or observation services ○ Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." ○ Sometimes you can be in the hospital overnight and still be an "outpatient." ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101 • 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 • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	**Prior Authorization (approval in advance) may be required. Please contact the plan for details.**

Services covered by our plan	Limitations and exceptions
Over-the-Counter (OTC) Items The plan covers limited OTC items available by mail and select CVS pharmacy retail stores at no cost to you. Contact Buckeye Health Plan for more information.	As an extra benefit, our plan covers up to $25 per calendar month for eligible over-the-counter (OTC) items. This OTC benefit is limited to one order per calendar month. Any unused amounts do not carry over to the next calendar month. Check the catalog for item limits. You can order up to three of the same item per calendar month unless otherwise noted in the catalog. There is no limit on the number of total items in your order. This benefit can only be used to order OTC products for the member.

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 • Certain telehealth services, including those for: primary care, specialist and other health care professional services, and outpatient mental health specialty services, including psychiatric care. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for members with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	None

Services covered by our plan	Limitations and exceptions

Physician/provider services, including doctor's office visits (continued)
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  ○ You have an in-person visit within 6 months prior to your first telehealth visit
  ○ You have an in-person visit every 12 months while receiving these telehealth services
  ○ Exceptions can be made to the above for certain circumstances
  • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  ○ you're not a new patient **and**
  ○ the check-in isn't related to an office visit in the past 7 days **and**
  ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:
  ○ you're not a new patient **and**
  ○ the evaluation isn't related to an office visit in the past 7 days **and**
  ○ **This benefit is continued on the next page**	

Services covered by our plan	Limitations and exceptions

Physician/provider services, including doctor's office visits (continued)
• the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
• Second opinion by another network before surgery
• 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.
	None

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

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. Refer to “Vision Care” later in this section page 91 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.
	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 specialist 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.	

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 get 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. • 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.	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
Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD). The plan will pay for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	None

Services covered by our plan	Limitations and exceptions
Transportation for non-emergency services (also refer to "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 Health Plan will provide transportation to and from the provider's office. **Note**: In addition to the transportation assistance that Buckeye Health Plan 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 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 (for example, when you are outside the plan's service area or during the weekend). ○ Buckeye Health Plan 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. 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 (refer to Chapter 1, Section D, page 9) 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 37 for more information.

F. Benefits covered outside of Buckeye Health Plan

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

F1. Hospice care

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. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Buckeye Health Plan 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:

- 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 Health Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3, page 111.

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, 7 days a week, 365 days a year.

G. Benefits not covered by Buckeye Health Plan, 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. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9, Section D, page 159.

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. Refer to Chapter 3, Section J1, page 41 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 necessary and Medicare covers it.
- A private room in a hospital, except when it is medically necessary.
- 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.

- 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 necessary.
- 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.
- 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).

Chapter 5: Getting your outpatient prescription drugs through the plan

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. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Buckeye Health Plan 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, refer to the Benefits Chart in Chapter 4, Section D, page 50.

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, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. 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.
    - Refer to Chapter 9, Section F2, page 179 to learn about asking for an exception.

5. 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 medical references.

Table of Contents

A. Getting your prescriptions filled

A1. Filling 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 use 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.

A2. Using 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 or 24-hour Nurse Advice Call Line or your care manager.

A3. What to do if you 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 there are any refills left.

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

A4. What to do if your pharmacy 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.

A5. Using 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 dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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.

A6. Using 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 that are not available through the plan's mail-order service are marked with "NM" 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.

Filling 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 mmp.buckeyehealthplan.com.

Usually, a mail-order prescription will get to you within 10-14 days. If your order is delayed, call Member Services or CVS Caremark at 1-866-808-7471 (TTY: 711).

Mail-order processes

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**

   The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

   - You used mail-order services with this plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by contacting CVS Caremark at 1-866-808-7471 (TTY: 711).

   If you get a prescription automatically by mail that you do not want, and you were not contacted to find out if you wanted it before it shipped, you may be eligible for a refund.

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling CVS Caremark at 1-866-808-7471 (TTY: 711).

   If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel 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.

   To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, please contact us by calling CVS Caremark at 1-866-808-7471 (TTY: 711).

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

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling CVS Caremark at 1-866-808-7471 (TTY: 711).

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 should verify your contact information each time you place an order, at the time you enroll in the automatic refill program or if your contact information changes.

A7. Getting 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. Refer to the section above page 99 to learn about mail-order services.

A8. Using 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 and need a drug that you can't get at a network pharmacy close to you.
- You need a drug urgently and there is no network pharmacy that is close to you and open.
- You must leave your home due to a federal disaster or other public health emergency.

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 find out 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, refer to Chapter 7, Section A, page 122.

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.

B1. Drugs on the Drug List

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

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs *or* biological products and usually cost less. There are generic drug substitutes *or* biosimilar alternatives available for many brand name drugs and some biological products.

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.

B2. How to find a drug 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 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.

B3. Drugs that are 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 Health Plan 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, refer to Chapter 9, Section F5, page 184.)

Here are three general rules for excluded drugs:

1. 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 Health Plan for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references 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 says that you have to have tests or services done only by them

B4. Drug List 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.
- Tier 2 (Brand Drugs) includes brand drugs and may include some generic drugs.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescription and over the counter (OTC) generic and brand drugs that are covered by Ohio Medicaid.

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

Chapter 6, Section C1, page 117 tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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 prescribe 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, refer to Chapter 9, Section F2, page 179.

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 Health Plan before you fill your prescription. If you don't get approval, Buckeye Health Plan 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.

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 mmp.buckeyehealthplan.com.

D. Reasons 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, 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.

D1. Getting 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.
     - 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 at a retail pharmacy and a 31-day supply at a long-term care pharmacy.
     - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
    - 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 at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy.
    - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small 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 temporary supply.
    - If your level of care changes, we will cover a temporary supply of your drugs. A level of care change happens when you are released from a hospital. It also happens when you move to or from a long-term care facility.
    - If you move home from a long-term care facility or hospital and need a temporary supply, we will cover one 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.
    - If you move from home or a hospital to a long-term care facility and need a temporary supply, we will cover one 31-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 31-day supply
    - 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, they 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, refer to Chapter 9, Section F2, page 179.

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, but Buckeye Health Plan may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from Buckeye Health Plan before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless**:**

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**

- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Buckeye Health Plan's up to date Drug List online at mmp.buckeyehealthplan.com **or**
- Call Member Services to check the current Drug List at 1-866-549-8289 (TTY: 711), 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.

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9, Section F2, page 179 of this handbook for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. You can talk to your doctor about other options.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**

- Replace a brand name drug currently on the Drug List **or**
- Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9, Section F2, page 179.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. 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.

F2. 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.

F3. 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. Refer to 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, refer to Chapter 4, Section F1, page 92.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, 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. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

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.

G3. Drug management program to help members safely use their opioid medications

Buckeye Health Plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacies** and/or **from certain doctors**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9, Section F6, page 186.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

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

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.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 mmp.buckeyehealthplan.com. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.

- Chapter 5, Section A, page 98 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 A1, page 98.

Table of Contents

A. The *Explanation of Benefits* (EOB)

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

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total Medicare Part D out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep 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 covered 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, refer to Chapter 7, Section A, page 122 for information about what to do.

3. **Check the EOBs we send you.**

   When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing or if you have any questions, please call Member Services. Instead of receiving a paper EOB in the mail, you now have the option of receiving an electronic EOB (eEOB). You may request the eEOB by visiting www.caremark.com. If you choose to opt-in, you will receive an email when your eEOB is ready to view, print or download. The eEOBs are also known as paperless EOBs. Be sure to keep these EOBs. 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 Health Plan, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. 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 Health Plan's Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 (Generic Drugs) includes generic drugs. The copay is $0.
- Tier 2 (Brand Drugs) includes brand drugs and may include some generic drugs. The copay is $0.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescription and over-the-counter (OTC) generic and brand drugs that are covered by Ohio Medicaid. The copay is $0.

C2. 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, refer to Chapter 5, Section A7, page 101 or the *Provider and Pharmacy Directory*.

C3. What 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. Refer to Chapter 5, Section A8, page 101 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, refer to the plan's *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines-Our plan covers most Medicare Part D vaccines at no cost to you. 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.

D1. What you need to know 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 Health Plan to ensure that you do not have any upfront costs for a Part D vaccine.

D2. What 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, refer to the Benefits Chart in Chapter 4, Section D, page 50.
- 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

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Asking 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, refer to page 122.

- 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 Health Plan 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. Show your Buckeye Health Plan Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because Buckeye Health Plan pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- 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:
  - You travel outside the plan's service area and need a drug that you can't get at a network pharmacy close to you.
  - You need a drug urgently and there is no network pharmacy that is close to you and open.
  - You must leave your home due to a federal disaster or other public health emergency.

Generally, we will cover a one-time fill up to a 30-day supply at an out-of-network pharmacy 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, 365 days a year if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 208 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 mmp.buckeyehealthplan.com/mmp/appeals-grievances.html.

B. How to avoid payment problems

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

   Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked Buckeye Health Plan for a coverage decision (refer to Chapter 9, Section D, page 159), 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 going to an out-of-network provider.**

   - Exceptions to this rule are:
     - if you need out-of-network emergency or urgent care services, **or**
     - 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 Health Plan.
     - If the out-of-network provider is approved by Buckeye Health Plan, you should not have to pay anything.
     - If the out-of-network provider will not bill Buckeye Health Plan 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 use 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 (PA) 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 use 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.**

   Refer to Chapter 3, Section B, page 29 for the rules about getting your health care, behavioral health, and other services. Refer to Chapter 5, Section A, page 98 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 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 health 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

Introduction

In this chapter, you will find legal notices that apply to your membership in Buckeye Health Plan and your rights and responsibilities as a plan member. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Legal notices

A1. Notices 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.

A2. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, or sex.

If you want more information or 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 users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 1-866-227-6353. TTY users can call 711.

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

A3. 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.

A4. Independent contractors

The relationship between Buckeye Health Plan and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Buckeye Health Plan and neither Buckeye Health Plan, nor any employee of Buckeye Health Plan, is an employee or agent of a participating provider. In no case will Buckeye Health Plan be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Buckeye Health Plan, maintain the physician-patient relationship with the member. Buckeye

Health Plan is not a provider of health care.

A5. Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, member, employer, or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by, for example, filing a claim that contains a false or deceptive statement is guilty of health care plan fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-866-549-8289 (TTY: 711). The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

A6. Circumstances beyond Buckeye Health Plan's control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in Buckeye Health Plan's facilities or personnel not being available to provide or arrange for services or benefits under this *Member Handbook*, Buckeye Health Plan's obligation to provide such services or benefits shall be limited to the requirement that Buckeye Health Plan make a good-faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

B. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. Each year you are in our plan, we must also 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 free interpreter services available to 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. Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) wants to make sure you understand your health plan information. We can send future materials to you in Spanish or in alternate formats if you ask for it this way. This is called a "standing request." We will document your choice.
Please call us if:

- You want to get your materials in Spanish or in an alternate format; or
- You want to change the language (English/Spanish) or format that we send you materials.

If you need help understanding your plan materials, please contact Buckeye Health Plan Member Services 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.

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, 7 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call 7-1-1.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Su derecho a obtener información y servicios de manera tal que satisfaga sus necesidades

Debemos garantizar que **todos** los servicios se le proporcionen de una manera accesible y culturalmente competente. Además, todos los años que usted forme parte de nuestro plan, debemos explicarle los beneficios del plan y sus derechos de una manera que usted pueda comprender.

- Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios al Afiliado. Nuestro plan ofrece servicios de interpretación gratuitos para responder preguntas en diferentes idiomas.

El plan también puede proporcionarle material en otros idiomas, además del inglés, y en distintos formatos como en braille, en audio o en letra grande. En el plan Buckeye Health Plan – MyCare Ohio (Plan de Medicare-Medicaid), queremos asegurarnos de que usted entiende la información de su plan de salud. En el futuro, podemos enviarle los materiales en español o en formatos alternativos si así los solicita. Esto se denomina “solicitud permanente”. Guardaremos su elección.
Llámenos en los siguientes casos:

- Si quiere recibir sus materiales en español o bien en un formato alternativo.

o

- Si quiere cambiar el idioma (inglés/español) o el formato en el que le enviamos los materiales.

Si necesita ayuda para entender los materiales de su plan, comuníquese con el Departamento de Servicios al Afiliado de Buckeye Health Plan al 1-866-549-8289 (TTY: 711). El horario de atención es de lunes a viernes, de 8:00 a. m. a 8:00 p. m. Es posible que fuera del horario de atención, los fines de semana y los días feriados le pidan que deje un mensaje. Lo llamaremos el siguiente día hábil.

Si tiene dificultades para obtener información de nuestro plan por problemas relacionados con el idioma o una discapacidad y quiere presentar una queja, comuníquese con:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- También puede llamar a la línea directa de Medicaid de Ohio 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.
- La Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

C. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to get all services that Buckeye Health Plan 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 find 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. You can find more information about choosing a PCP in Chapter 3, Section D1, page 31.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a network women's health specialist for covered women's health services without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.

- 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.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- 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 use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D4, page 35.

Chapter 9, Section C, page 158 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 D, page 159 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. Our responsibility to protect your personal health information (PHI)

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

- Your PHI 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 related to your information and to control how your PHI 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 PHI.

D1. How we protect your PHI

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 find or change your records.

Except for the cases noted below, we do not give your PHI 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 PHI to government agencies that are checking on our quality of care.
- We are required to release PHI by court order.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

D2. You have a right to look at 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 PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, 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.

Effective 03.01.2018

For help to translate or understand this, please call 1-866-549-8289. Hearing impaired TTY: 711.
Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-866-549-8289. (TTY: 711).

COVERTED 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 maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Buckeye Health Plan – MyCare Ohio (MMP) reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Buckeye Health Plan – MyCare Ohio (MMP) will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website.

INTERNAL PROTECTIONS OF ORAL, WRITTEN AND ELECTRONIC PHI:

Buckeye Health Plan – MyCare Ohio (MMP) protects your PHI. We have privacy and security processes to help.

These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

PERMISSIBLE 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 health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. 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 healthcare 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 healthcare professionals
- case management and care coordination
- detecting or preventing healthcare fraud and abuse.

- ***Group Health Plan/Plan Sponsor Disclosures*** – We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

OTHER PERMITTED OR REQUIRED DISCLOSURES OF YOUR PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- ***Underwriting Purposes*** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose.
- ***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 information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports 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 necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** - 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 the use or disclosure is necessary to prevent or lessen a serious or imminent threat 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, 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 incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection 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 limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposed with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

INDIVIDUALS RIGHTS

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

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care 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 request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- ***Right to Access and Received 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 request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written

explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI -*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures -*** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting 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 provide you with 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 in writing or by phone using the contact information at the end of this Notice.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201 or calling 1-800-368-1019 (TTY: 1-866-788-4989), or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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

- ***Right to Receive a Copy of this Notice -*** You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to 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 or by phone using the contact information listed below.

Buckeye Health Plan - MyCare Ohio (MMP)
Attn: Privacy Official
4349 Easton Way, Suite 120
Columbus, OH 43219
1-866-549-8289
TDD/TTY: 711

E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of Buckeye Health Plan, 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. We can also give you information in large print, braille, or audio. Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) wants to make sure you understand your health plan information. We can send future materials to you in Spanish or in alternate formats if you ask for it this way. This is called a “standing request.” We will document your choice. Please call us if:

- You want to get your materials in Spanish or in an alternate format; or
- You want to change the language (English/Spanish) or format that we send you materials.

If you need help understanding your plan materials, please contact Buckeye Health Plan Member Services 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.

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

- How to choose or change plans
- 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

- 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. We must send you something in writing that says who the new PCP is and the date the change began.
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network
  - A list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at mmp.buckeyehealthplan.com.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

F. Inability of network providers to 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, refer to Chapter 7, Section A, page 122.

G. Your 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.
- Refer to Chapter 10, Section C, page 214 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.

H. Your right to make decisions about your health care

H1. Your 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. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices** and be told about all the kinds of treatment provided in a way appropriate to your condition and ability to understand.
- **Know the risks** and 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.
- **Get a second opinion** by using another qualified network provider before deciding on treatment.
    - If a qualified network provider is not able to find you, we will arrange a visit with a non-network provider at no cost to you.
- **Say "no"** and 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.
    - stop taking a drug.
  - If you say no to treatment, therapy or taking a drug, the doctor or Buckeye Health Plan 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.

- **Ask us to explain why a provider denied care** and get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section D, page 159 tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles** and refuse treatment from a student.

H2. Your 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: www.proseniors.org/advance-directives/.

- **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. 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.

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: donatelife.ohio.gov

H3. 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.

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section C, page 158 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.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

You are free to exercise all of your rights knowing that Buckeye Health Plan, 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 in Chapter 11 or you would like more information about your rights, you can get help by calling:

- Member Services.
- The Ohio Medicaid Consumer Hotline at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The MyCare Ohio Ombudsman in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8:00 am to 5:00 pm. Refer to Chapter 2, Section H, page 26 for more information about this organization.

J. Your 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, refer to Chapters 3, Section A, page 29 and Chapter 4, Section A, page 46. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to Chapters 5, Section A, page 98 and Chapter 6, Section C, page 117.
- **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 Health Plan 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.

  - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. **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 refer to Chapter 9, Section D, page 159 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 service area, you cannot stay in this plan.** Only people who live in our service area can get Buckeye Health Plan. Chapter 1, Section D, page 9 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. Refer to Chapter 2, Section F, page 24 and Section G, page 25 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. Refer to Section K in Chapter 1 for more information. 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.

J1. Estate recovery program

If you are permanently institutionalized or age 55 or older when you get Medicaid benefits, the Estate Recovery Program may recover payments from your estate for the cost of your care paid by Ohio Medicaid. The cost of your care may include the capitation payment that Ohio Medicaid pays to your managed care plan, even if the payment is greater than the cost of the services you got. Estate recovery happens after your death.

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

Introduction

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 to help guide you through your problem.**

For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section H, page 26 for more information on ombudsman programs.

Table of Contents

A. 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.

A1. 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,” “benefit determination,” “at-risk 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.

B. Where to call for help

B1. 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 Health Plan’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 mmp.buckeyehealthplan.com to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 208 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 Health Plan 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:

For medical questions, problems, complaints or appeals:

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

For Part D drug appeals:

Buckeye Health Plan – MyCare Ohio
Medicare Part D Appeals
PO Box 31383
Tampa, FL 33631-3383

For Part D drug questions, problems or complaints:

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

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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. The call is free. You can also visit the Ohio Department of Medicaid website at 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 is an ombudsman program that can help you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. Refer to Chapter 2, Section H, page 26 for more information on ombudsman programs.

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 am to 5:00 pm. You can also submit an online complaint at: 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 at 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 them 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 by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at 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 Aid 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.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making 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. Refer to **Section D: "Coverage decisions and appeals"** on page 159.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 202.

D. Coverage decisions and appeals

D1. 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 B1 on page 155.

D2. Using the section of this chapter that 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 E on page 162** 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:
  - 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 E for problems with drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with an "NT" are **not** covered by Part D. Refer to Section F on page 177 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. Refer to Sections G and H on pages 188 and 195.
  - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your

request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F on page 177** 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 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 authorization (PA) or 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 G on page 188** 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 H on page 195** 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).

E. Problems about services, items, and drugs (not Part D drugs)

E1. 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, including Medicare Part B drugs. Drugs in the Drug List with an "NT" are not covered by Part D. Use Section F 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. Refer to Section E2 on page 164 for information on asking for a coverage decision.

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

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 164 for information on asking for a coverage decision.

   NOTE: Refer to the Benefits Chart in Chapter 4, Section D, page 50 for a general list of covered services as well as information on what services require PA from our plan. Refer to the Drug List to find out if any drugs require PA. You can also find the lists of services and drugs that require PA at 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. Refer to Section E3 on page 166 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. Refer to section E3 on page 166 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. Refer to Section E3 on page 166 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. Refer to Section E5 on page 176 of this section 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. Refer to Section E3 on page 166 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 171.

   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 G or H on pages 188 and 195 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. Refer to Section J on page 202 for information on making a complaint. Refer to Section E3 on page 166 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. Refer to Section J on page 202 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. Refer to Section E4 on page 171 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).

E2. Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (refer to Section F 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
  349 Easton Way, Suite 120
  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, refer to Section B1 on page 155.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid or Medicare Part B prescription drugs within 72 hours after we receive your request.

We will make a standard coverage decision on all other services and items within 10 calendar days after you asked. If we don't give you our decision within 10 calendar days (or 72 hours for a Medicare Part B prescription drug), 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. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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 or Medicare Part B prescription drugs and within 48 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. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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. 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 details on how to contact us, refer to Chapter 2, Section A, page 17.
- 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 ask for 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 or Medicare Part B prescription drugs and 10 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 (72 hours for Medicaid or Medicare Part B prescription drugs) 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, refer to Section J on page 202.

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).

E3. 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 them as your representative in writing. Read "Can someone else make the appeal for me" on page 166 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 find out 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.

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 60 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?

- 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) 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

  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.
- If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 208. Be sure to include your first and last name, the number from the front of your Buckeye Health Plan 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, refer to Chapter 2, Section A, page 17.

- 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.

If we don’t get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at 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 60 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. You should explain the reason your appeal is late when you make your 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 171 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free 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 find out 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 (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). 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 decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for Medicare Part B prescription drug.
- 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, refer to Section J on page 202.
- If we do not give you an answer to your appeal within 15 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) 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 (refer to Section E4 on page 171). 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 (refer to Section E4 on page 171).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 202).

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 (or within 7 days after we get your appeal for a Medicare Part B prescription drug).

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 (refer to Section E4 on page 171). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 171).

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you our 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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, refer to Section J on page 202.
- 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 (refer to Section E4 on page 171). 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 (refer to Section E4 on page 171).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 202).

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 (refer to Section E4 on page 171). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 171).

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; or (2) 15 calendar days pass after we notify you that we said **No** to your appeal.

NOTE: Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you ask for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision. If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process. For more information, refer to Section E4 on page 171.

E4. 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 **Medicaid** service or item, the letter will tell you that you may ask for a State Hearing. Refer to page 171 of this section for information on State Hearings.

- 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 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 tell you that you may also ask for a State Hearing. Refer to page 171 of this section for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicaid, you may ask for a State Hearing.

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 120 calendar days** of the date that we sent the notice of your State Hearing rights. The 120 calendar days begins on the day after the mailing date on the notice. If you miss the 120 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 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.

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.

My problem is about a service or item that is covered by Medicare. What will happen at the Level 2 Appeal?

If we say No to your Appeal at Level 1 and the service or item is usually covered by Medicare, you will automatically get a Level 2 Appeal from the Independent Review Entity (IRE). 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.

How long does it take to get an IRE decision?

- The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

- If you had a "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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a State Hearing. To ask for a State hearing, follow the instructions in this section on page 171.

Will my benefits continue during Level 2 appeals?

If we decide to change or stop coverage for a service that was previously approved, you can ask to continue your benefits during Level 2 Appeals in some cases.

- If your problem is about a service primarily covered by **Medicaid only,** you can ask to continue your benefits during Level 2 appeals. 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 letter telling you that we denied your Level 1 appeal; **or**
    - The intended effective date of the action.
- 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 automatically continue during the Level 2 appeal process with the IRE. If you also ask for a State Hearing, you can continue your benefits while the hearing is pending if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; (2) all entities that got your Level 2 Appeal (the IRE and/or Bureau of State Hearings) decide **No** to your request.

How will I find out about the decision?

If your Level 2 Appeal was a State Hearing, 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 the Level 1 decision. 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.

If your Level 2 Appeal went to the Independent Review Entity (IRE), 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 **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 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?

If your Level 2 Appeal was a State Hearing, you can appeal again by asking for 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.

If your Level 2 Appeal went to the Independent Review Entity (IRE), 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 IRE will explain additional appeal rights you may have.

Refer to Section I on page 201 for more information on additional levels of appeal.

E5. 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. 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 find out if the service or item you paid for is a covered service or item, and we will check 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.

- 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 E3 on page 166. 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. Refer to Section I on page 201 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 (refer to Section E4 on page 171).

F. Part D drugs

F1. 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 Drug List includes some drugs with an "NT". These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an "NT" symbol follow the process in **Section E** on page 162.

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 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 198you (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 ask us to pay you 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.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 179. Also refer to Sections F3 and F4 on pages 180 and 181.	Skip ahead to **Section F4** on page 181.	Skip ahead to **Section F4** on page 181.	Skip ahead to **Section F5** on page 184.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List 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 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, refer to Chapter 5, Section B, page 102).

    - 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" (PA).)
        - 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."**

F3. 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 F5 on page 184 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.

F4. 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. Include your name, contact information, and information about the claim.
- 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 B on page 155 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.
- If you paid for a drug that you think should be covered, read Chapter 7, Section A, page 122 of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.

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 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.

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

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, refer to Section J on page 202.

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, this means within 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, this means within 72 hours 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.

F5. Level 1 Appeal for Part D drugs

To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.

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.

- 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.

> **The legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

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 F4 on page 181.

> **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 find out 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, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. 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, or 14 calendar days if you asked us to pay you back for a drug you already bought, 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 or 14 calendar days if you asked us to pay you back for a drug you already bought.

    - 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.

F6. 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.

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.

- 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.

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, or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - 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.

G. 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.

G1. 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 refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. 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 find out if your planned discharge date is medically appropriate for you.

In Ohio, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: **1-888-524-9900 (TTY: 1-888-985-8775)**.

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 1-888-524-9900 (TTY: 1-888-985-8775) 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, refer to Section G4 on page 193.

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 refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

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.

G3. 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 Livanta. You can reach Livanta at: **1-888-524-9900 (TTY: 1-888-985-8775)**.

- 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 1-888-524-9900 (TTY: 1-888-985-8775) 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.

G4. What happens if you 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 (which is within 60 days or no later than your planned discharge date, whichever comes first), 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 find out 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 J on page 202 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.

H. 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.

H1. 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 we will stop covering your care and 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.

H2. 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 J on page 202 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 Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). 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 1-888-524-9900 (TTY: 1-888-985-8775) and ask 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, refer to Section H4 on page 199.

> **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 refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

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.

H3. 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 Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). 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.

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 1-888-524-9900 (TTY: 1-888-985-8775) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement 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.

H4. What happens 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 find out if the decision about when your services should end was fair and followed all the rules.

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.

- 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.”
- **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 J on page 202 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 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.

- 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.
- **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.

I. Taking your appeal beyond Level 2

I1. 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. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator 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 or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can contact 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).

I2. 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.

J. How to make a complaint

J1. 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 Health Plan staff treated you poorly.
- You think you are being pushed out of the plan.

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 J3 on page 205.

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 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.

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).**

J2. 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 can be made **at any time** 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 208 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.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: 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 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 www.hhs.gov/ocr.

You may also contact the local Office for Civil Rights office at:

Ohio Department of Job and Family Services
Bureau of Civil Rights
30 East Broad Street, 30th Floor
Columbus, Ohio 43215

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. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section E, page 23.

In Ohio, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

J4. Member complaint and appeal form

To file a complaint or appeal, call, write, or fax Buckeye Health Plan. Or you can use the form on page 208 and fax or mail it to:

For medical questions, problems, complaints or appeals:

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

Fax: 1-844-273-2671

For Part D drug appeals:

Buckeye Health Plan – MyCare Ohio
Medicare Part D Appeals
PO Box 31383
Tampa, FL 33631-3383

Fax: 1-866-388-1766

For Part D drug questions, problems or complaints:

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

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 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 Complaint & Appeal Form

Complete and mail or fax to:
Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan)
Attention: Appeals and Grievances – Medicare Operations
7700 Forsyth Blvd | St. Louis, MO | 63105
Fax: 1-844-273-2641

Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) will have a resolution to your complaint no later than 30 Calendar days or,2 days for access of care, of the date you submit your complaint. 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. However, if we take this extension, we will notify you or your representative. We can usually help you right away or at the most within a few days. 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. If you have a "fast" complaint, it means we will give you an answer within 24 hours. If you need any help, call Member Services at 1-866-549-8289 / TTY/TDD 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. 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.

As a member of Buckeye Health Plan – MyCare Ohio (Medicare-Medicaid Plan) you have the right to file an appeal for any denials related to medical services (Part C) or prescription drug (Part B) coverage. You may file appeal requests in writing or by calling Member Services at 1-866-549-8289 / TTY: 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. 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 will give you a decision within the following timeframes from receiving your request:

Standard Medical Pre-Service Appeals: **15 calendar days**
Standard Part B Prescription Drug Related Appeals: **7 calendar days**
Expedited Medical Pre-Service Appeals: **72 hours**
Expedited Part B Prescription Drug Related Appeals:**72 hours**

Appeals related to payment issues For Part C and Part B drugs will be given a standard appeal decision within 60 calendar days of request receipt. 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 for Part C Pre Service. We will tell you or your representative in writing if we decide to take extra days to make the decision.

Expedited appeals *mean you feel that using the standard deadlines could cause serious harm to your life or health or jeopardize your ability to regain maximum function. You must also be asking for coverage for medical care or a drug you have not yet received.*

Member's Name: Last _____ First _____

Medicare ID Number:

_____

Member Date of Birth: _____

Relationship to Member* (please choose one): ☐ Self ☐ Parent ☐ Legal Guardian ☐ Spouse

☐ Other: _____

**If other than "Self" is selected, proof of guardianship, power of attorney or an Appointment of Representative (AOR) form will be required. The AOR form can be found on our website.*

Name of Person Submitting the Appeal:

_____

Phone Number(s): Home: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Physician: _____

Complaint Type (please choose one):

☐ Abuse, Neglect, Etortation Access
☐ Service Request, Claim Payment Issue/Appeals
☐ Prescription Drug Request or Issue/Coverage Determination & Redetermination Process
☐ Customer Service
☐ Enrollment & Disenrollment
☐ Fraud and Abuse
☐ Marketing
☐ Privacy Issues
☐ Quality of Care

Is this complaint about your medications? (please choose one): ☐ Yes ☐ No

If you answered YES above, do you have enough supply for the next 7 days? (please choose one):
☐ Yes ☐ No

What is your complaint? _____

How can Buckeye resolve your issue? _____

_____

_____

What is the best way to reach you regarding this complaint? (please choose one): ☐ Phone ☐ Email

☐ Other: _____

Please provide further contact information (i.e. phone number, email address, etc.):

_____

_____

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.

For Administrative Use Only

Complaint Number: _____ Date Received: _____

Appeal Type (please choose one):

☐ Standard Pre-Service (Medical) Appeal – (15 calendar days review)
☐ Expedited Pre-Service (Medical Appeal – (72 hours review)
☐ Standard Part B (Prescription Drug) Appeal – (7 calendar days review)
☐ Expedited Part B (Prescription Drug) Appeal – (72 hours review)
☐ Standard Payment Issues Appeal (Part C and Part B drugs) – (60 calendar days review)

What was denied? (Please include a copy of the denial letter.)

_____
_____
_____
_____
_____

Why do you think you should have <this/these> medical service(s)/prescription or payment?

_____
_____
_____
_____
_____

What is the best way to reach you regarding this appeal? (please choose one): ☐ Phone ☐ Email ☐ Other: _____

Signature of Person Appealing: _____ Date: _____

If you have any questions please call our Member Services number at 1-866-549-8289 / TTY: 711, Monday through Friday, 8:00 a.m. to 8:00 p.m. 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) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

For Administrative Use Only

Appeal Number: _____ *Date Received:* _____

Chapter 10: Changing or ending your membership in our MyCare Ohio Plan

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. If you leave our plan, you will still be in the Medicare and Ohio Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. MyCare Ohio

You can end your membership in Buckeye Health Plan Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

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.

You can get more information about when you can change or end your membership by calling:

- The Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5, Section G3, page 112 for information about drug management programs.

B. How to 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. 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, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. 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 page 215.

Refer to Section A above for information on when your request to change or end your membership will take effect.

C. How to 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.

Your coverage with Buckeye Health Plan will end on the last day of the month that we get your request.

D. How to get Medicare and Medicaid services

If you do not want to enroll in a different MyCare Ohio plan, you will return to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by Buckeye Health Plan.

D1. Ways to get your 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: **A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye Health Plan 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, 7 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye Health Plan 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 have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call your SHIP Program, the Ohio Senior Health Insurance Information Program (OSHIIP) at 1-800-686-1578, from 7:30 a.m. to 5 p.m., Monday through Friday. TTY users can call 711.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. You will automatically stop getting Medicare services through Buckeye Health Plan when your Original Medicare coverage begins.

D2. How to get your 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 Health Plan or another MyCare Ohio managed care plan.

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 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.

E. Keep getting your Medicare and Medicaid services through our plan until your membership ends

If you change or end your enrollment with Buckeye Health Plan, it will take time before your new coverage begins. Refer to page 213 for more information. During this time, keep getting your Medicare and Medicaid services through our plan.

- Use our network providers to receive medical care.
- **Use our network pharmacies** including through our mail-order pharmacy services **to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in Buckeye Health Plan changes or ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

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 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. Rules against asking you to leave our plan for any health-related reason

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, 7 days a week.

You should also call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.

H. Your 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 refer to Chapter 9, Section J, page 202 for information about how to make a complaint.

I. How to 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

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

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.

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. For more information, refer to Chapter 9, Section D, page 159.

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. For more information, refer to Chapter 5, Section B, page 102.

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. For more information, refer to Chapter 1, Section C, page 8.

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. For more information, refer to Chapter 1, Section G, page 10.

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. For more information, refer to Chapter 1, Section C, page 8.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS. For more information, refer to Chapter 2, Section F, page 24.

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. For more information, refer to Chapter 9, Section J, page 202.

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. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 9, Section E2, page 164.

Covered Drugs: The term we use to mean all of the prescription drugs covered by our plan. For more information, refer to Chapter 5, Section B, page 102.

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. For more information, refer to Chapter 4, Section A, page 46.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). For more information, refer to Chapter 10, Section B, page 214.

Drug tiers: Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three tiers.

Durable Medical Equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers. For more information, refer to Chapter 3, Section L, page 43.

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. For more information, refer to Chapter 4, Section D, page 50.

Emergency Care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. For more information, refer to Chapter 3, Section H, page 37.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations. For more information, refer to Chapter 5, Section D, page 105.

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." For more information, refer to Chapter 6, Introduction, page 114.)

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. For more information, refer to Chapter 5, Section B, page 102.

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. For more information, refer to Chapter 9, Section J, page 202.

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. For more information, refer to Chapter 1, Section F, page 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. For more information, refer to Chapter 1, Section C, page 8.

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. For more information, refer to Chapter 4, Section D, page 50.

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 Health Plan must give you a list of hospice providers in your geographic area. For more information, refer to Chapter 4, Section D, page 50.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Buckeye Health Plan Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

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. For more information, refer to Chapter 4, Section D, page 50.

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 there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary." For more information, refer to Chapter 1, Section J4, page 13.

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. For more information, refer to Chapter 3, Section E, page 35.

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. For more information, refer to Chapter 2, Section G, page 25.

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. For more information, refer to Chapter 3, Section B, page 29.

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”). For more information, refer to Chapter 2, Section F, page 24.

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

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. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 4, Section D, page 50.

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 Health Plan includes Medicare Part D. For more information, refer to Chapter 5, Section B, page 102.

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. For more information, refer to Chapter 5, Section A, page 98.

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. For more information, refer to Chapter 1, Section E, page 9.

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. For more information, refer to Chapter 8, Section D2, page 133.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. For more information, refer to Chapter 2, Section A, page 17.

Model of Care: The structured and integrated approach Buckeye Health Plan 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. For more information, refer to Chapter 5, Section A1, page 98.

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.” For more information, refer to Chapter 3, Section A, page 29.

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. For more information, refer to Chapter 4, Section D, page 50.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman’s services are free. For more information, refer to Chapter 2, Section H, page 26.

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. For more information, refer to Chapter 9, Section D, page 159.

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 use 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.
- Covered drugs that need our plan's prior authorization (PA) are marked in the *List of Covered Drugs*.

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. For more information, refer to Chapter 5, Section A8, page 101.

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. For more information, refer to Chapter 3, Section D, page 31.

- **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."

Over-the-counter (OTC) Drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Buckeye Health Plan's Notice of Privacy Practices for more information about how Buckeye Health Plan protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

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. For more information, refer to Chapter 3, Section D, page 31.

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, Section D, page 50. 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*. For more information, refer to Chapter 3, Section B, page 29.

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. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 2, Section E, page 23.

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. For more information, refer to Chapter 5, Section C, page 104.

Rehabilitation Services: Treatment you get to help you recover from an illness, accident or major operation. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 1, Section D, page 9.

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. For more information, refer to Chapter 4, Section D, page 50.

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. For more information, refer to Chapter 4, Section D, page 50.

Specialist: A doctor who provides health care for a specific disease or part of the body. For more information, refer to Chapter 3, Section D, page 31.

State Hearing: A chance for you to tell your problem to a state representative and show that a decision we made is wrong. For more information, refer to Chapter 9, Section E4, page 171.

State Medicaid Agency: The Ohio Department of Medicaid. For more information, refer to Chapter 2, Section G, page 25.

Step Therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for. For more information, refer to Chapter 5, Section C, page 104.

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. For more information, refer to Chapter 3, Section H, page 37.

Multi-Language Insert

Multi-Language Interpreter Services

ATENCIÓN: Si habla español, contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. Llame al **1-866-549-8289** (TTY: **711**), de 8 a.m. a 8 p.m., de lunes a viernes. Después del horario de atención, los fines de semana y días feriados, es posible que se le solicite dejar un mensaje. Se le devolverá la llamada el siguiente día hábil. La llamada es gratuita.

注意：如果您説中文，您可以免費獲得語言協助服務。請致電 **1-866-549-8289** (TTY：**711**)，服務時間為週一至週五，早上 8 點到晚上 8 點。非服務時間、週末和假日，您可能會需要留言。我們將在下一個工作日內回電給您。此為免付費專線。

PAALALA: Kung nagsasalita ka ng Tagalog, may mga available na libreng tulong sa wika para sa iyo. Tumawag sa **1-866-549-8289** (TTY: **711**), 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Pagkalipas ng oras ng trabaho, tuwing Sabado at Linggo, at sa mga holiday, posibleng hilingin sa iyo na mag-iwan ng mensahe. Tatawagan ka sa susunod na araw ng negosyo. Libre ang tawag.

ATTENTION : si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le **1-866-549-8289** (TTY : **711**) du lundi au vendredi, de 8 h à 20 h. En dehors des heures d'ouverture et durant le week-end et les jours fériés, il vous sera peut-être demandé de laisser un message. Vous serez rappelé le jour ouvrable suivant. L'appel est gratuit.

LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Vui lòng gọi **1-866-549-8289** (TTY: **711**), từ 8 a.m. đến 8 p.m., Thứ Hai đến Thứ Sáu. Sau giờ làm việc, vào cuối tuần và ngày lễ, quý vị có thể được yêu cầu để lại tin nhắn. Cuộc gọi của quý vị sẽ được trả lời vào ngày làm việc tiếp theo. Cuộc gọi này được miễn phí.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Übersetzungsdienst zur Verfügung. Wählen Sie dafür **1-866-549-8289** (TTY: **711**) von Montag bis Freitag zwischen 8 und 20 Uhr. Außerhalb dieser Zeiten, an Wochenenden und Feiertagen werden Sie möglicherweise gebeten, eine Nachricht zu hinterlassen. Ihr Anruf wird innerhalb des nächsten Arbeitstages beantwortet. Der Anruf ist kostenlos.

주의: 한국어를 구사할 경우, 언어 보조 서비스를 무료로 이용 가능합니다. 해당 서비스는 **1-866-549-8289**(TTY: **711**)번으로, 월요일~금요일, 오전 8시부터 오후 8시까지 문의해 주십시오. 근무시간 이후나 주말 및 공휴일에는 메시지를 남겨 주시면 됩니다. 그러면 다음 근무일에 전화드리겠습니다. 통화는 무료입니다.

ВНИМАНИЕ: если вы говорите на русском языке, вы можете бесплатно получить помощь переводчика. Позвоните по номеру **1-866-549-8289** (TTY: **711**), с 8 a.m. до 8 p.m. с понедельника по пятницу. В нерабочее время, в выходные и праздничные дни вас могут попросить оставить сообщение. Вам перезвонят на следующий рабочий день. Звонки бесплатные.

انتباه: في حال كنت تتحدث اللغة العربية، تتوفر لك خدمات مساعدة لغوية مجانية. اتصل على الرقم **1-866-549-8289** (TTY: **711**)، من الساعة 8 صباحًا ولغاية الساعة 8 مساءً من الاثنين إلى الجمعة. وقد يُطلب منك ترك رسالة بعد انتهاء ساعات العمل وفي عطلات نهاية الأسبوع والإجازات. وستتم معاودة الاتصال بك خلال يوم العمل التالي. والاتصال مجاني.

ATTENZIONE: se parla italiano, sono disponibili gratuitamente servizi di assistenza linguistica. Chiami il numero **1-866-549-8289** (TTY: **711**), dalle 8:00 alle 20:00, dal lunedì al venerdì. Al di fuori di questa fascia oraria, nei fine settimana e nei giorni festivi è possibile che le venga chiesto di lasciare un messaggio. La sua chiamata sarà gestita entro il giorno lavorativo successivo. La chiamata è gratuita.

ATENÇÃO: se falar português, estão disponíveis serviços de assistência gratuitos no seu idioma. Ligue para o número **1-866-549-8289** (TTY: **711**) de segunda-feira a sexta-feira, das 8:00 às 20:00. Se ligar fora deste horário, num fim de semana ou num feriado, poderá ter de deixar mensagem. A sua chamada será devolvida no próximo dia útil. A chamada é gratuita.

ATANSYON: Si ou pale Kreyòl-Franse, sèvis asistans lang disponib gratis pou ou. Rele **1-866-549-8289** (TTY: **711**), soti lendi pou rive vandredi, 8è a.m. pou rive 8è p.m. Nan wikenn ak jou konje federal eta a, yo ka mande w pou kite yon mesaj. Y ap retounen w apèl la nan pwochen jou ouvrab la. Apèl la gratis.

UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-866-549-8289** (TTY: **711**), od poniedziałku do piątku, od 8 do 20. Poza godzinami pracy, w weekendy i święta państwowe może być konieczne zostawienie wiadomości. Nasz agent oddzwoni w kolejnym dniu roboczym. Połączenie jest bezpłatne.

ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए मुफ़्त में भाषा संबंधी सहायता सेवाएं उपलब्ध होंगी. सोमवार से लेकर शुक्रवार तक सुबह 8 बजे से लेकर रात 8 बजे तक **1-866-549-8289** (TTY: **711**) पर कॉल करें. उपरोक्त समय के अलावा, वीकेंड या छुट्टी के दिनों में आपको मैसेज छोड़ने के लिए कहा जा सकता है. आपके कॉल का जवाब अगले कामकाज के दिन के भीतर दे दिया जाएगा. यह कॉल मुफ़्त है.

注目：日本語を話す場合、言語支援サービスを無料でご利用いただけます。月曜日から金曜日の午前 8 時から午後 8 時の間に **1-866-549-8289**（TTY：**711**）までお電話ください。対応時間外や週末、祝日に電話をかけると、メッセージを残すか尋ねられる場合があります。次の営業日に折り返しお電話いたします。通話は無料です。

ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि भाषासम्बन्धी सहायता सेवाहरू निःशुल्क उपलब्ध छन्। सोमबारदेखि शुक्रबारसम्म, बिहान 8 बजेदेखि बेलुका 8 बजेसम्म **1-866-549-8289** (TTY: **711**) मा कल गर्नुहोस्। कामको नियमित समयबाहेक, साताको अन्तमा र बिदाका दिनहरूमा तपाईंलाई सन्देश छोड्न भन्न सकिन्छ। तपाईंको कलको जवाफ त्यसपछिको कार्यालय खुल्ने दिन भित्रमा दिइने छ। यो कलको शुल्क लाग्दैन।

FIIRO GAAR AH: Haddii aad ku hadasho af Soomaali, adeegyada caawimaada luuqada, oo bilaash ah, ayaad heli kartaa. Wac **1-866-549-8289** (TTY: **711**), 8 subaxnimo ilaa 8 habbeenimo, Isniinta ilaa Jimcaha. Saacadaha shaqada kadib, maalmaha fasaxa ee asbuuca iyo maalmaha guud ee fasaxa ah, waxaad codsan kartaa inaad reebto fariin. Waxaa dib laguu soo wici doonaa dhowrka maalmood ee xigga ee ah maalmaha shaqada. Wicitaankaan waa bilaash.

KUMBUKA: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha , za bila malipo, zinapatikana kwako. Piga simu kwa **1-866-549-8289** (TTY: **711**), 8 asubuhi hadi 8 usiku, Jumatatu hadi Ijumaa. Baada ya saa za kazi, katika wikendi au likizo, unaweza kuombwa uache ujumbe. Simu yako itajibiwa ndani ya siku inayofuata ya kazi. Simu hii ni ya bila malipo.

УВАГА: Якщо ви володієте українською мовою, вам безкоштовно доступні послуги мовної підтримки. Телефонуйте за номером **1-866-549-8289** (TTY: **711**) з 8:00 до 20:00 з понеділка по п'ятницю. У неробочий час, у вихідні та святкові дні вас можуть попросити залишити повідомлення. Ваш дзвінок буде оброблено протягом наступного робочого дня. Дзвінок безкоштовний.

INTANGAMARARA: Nimba uyaga Ikirundi, ubufasha mu vy'indimi, ku buntu, woburonka. Hamagara **1-866-549-8289** (TTY: **711**), Kuwa Mbere gushika kuwa Gatanu, 8 zo mu gatondo gushika 8 z'umuhingamo. Muri wikendi canke ku biruhuko, twogusaba kudusigira ubutumwa. Tuzokwishura ku guhamagara kwawe umunsi ukurikira w'akazi. Guhamagara ni ubuntu.

注意：如果您说中文普通话，则可以获得免费的语言协助服务。请在周一至周五上午 8 点至晚上 8 点致电 **1-866-549-8289** (TTY: **711**)。工作时间之外、周末以及节假日期间，会要求您留言。工作人员会在下一个工作日给您回电。此号码为免费电话。

توجه: اگر به زبان دری صحبت می کنید، خدمات کمک زبان به صورت رایگان در دسترس شما است. از دوشنبه تا جمعه، از 8 صبح تا 8 بعد از ظهر، با شماره **1-866-549-8289** (TTY: **711**) تماس بگیرید. در رخصتی های آخر هفته و در رخصتی های فدرال ایالتی، ممکن است از شما خواسته شود که پیام بگذارید. تماس شما ظرف یک روز کاری آینده برگردانده خواهد شد. تماس رایگان است.

ትኩረት፡ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እርዳታ አገልግሎቶች፣ በነጻ፣ ለእርስዎ ይገኛሉ። **1-866-549-8289** (TTY: **711**)፣ ከሰኞ እስከ አርብ፣ ከ 8 a.m. እስከ 8 p.m. ይደውሉ። በሳምንቱ መጨረሻ እና በክልል የፌዴራል በዓላት ላይ መልእክት እንዲተው ሊጠየቁ ይችላሉ። ጥሪዎ በሚቀጥለው የስራ ቀን ውስጥ ይመለሰል። ጥሪው ነፃ ነው።

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો તમારા માટે ભાષા સંબંધી સહાયતાની સેવાઓ વગર કોઈ શુલ્કે ઉપલબ્ધ છે. સોમવારથી શુક્રવાર દરમિયાન સવારે 8 વાગ્યાથી રાત્રે 8 વાગ્યા સુધી **1-866-549-8289** (TTY: **711**) પર કૉલ કરો. કામકાજના સમયની બહારના સમયે, શનિ-રવિએ અને રજાઓમાં, તમને મેસેજ છોડી દેવા માટે કહેવામાં આવી શકે છે. તમારા કૉલ માટે કામકાજના આગલા દિવસની અંદર વળતો કૉલ કરવામાં આવશે. એ કૉલ મફત હોય છે.

Buckeye Health Plan Member Services

CALL	1-866-549-8289. Calls to this number are 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. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are 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.
FAX	1-866-704-3064
WRITE	Buckeye Health Plan - MyCare Ohio 4349 Easton Way, Suite 120 Columbus, OH 43219
WEBSITE	mmp.buckeyehealthplan.com