2025 Member Handbook

buckeye health plan
Your Guide to Better Health™

BuckeyeHealthPlan.com • 1-866-246-4358 • TDD/TTY: 1-800-750-0750

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Notice

If you have a problem reading or understanding this information or any other Buckeye Health Plan information, please contact our Member Services at 1-866-246-4358 (TTY:711) for help at no cost to you.

We can explain this information, in English or in your primary language. You can get this document for free in other formats, such as large print, braille, or audio. Call 1-866-246-4358 (TTY:711) Monday through Friday 7 a.m. to 7 p.m. The call is free.

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

Other services offered on the website include:

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

This Member Handbook is effective January 2025.

Important Phone Numbers

Emergency: 911 or local emergency number

Buckeye Member Services: 1-866-246-4358

24-Hour Nurse Advice Line: 1-866-246-4358

Transportation Services: 1-866-246-4358

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

Member Services hours are Monday - Friday, 7:00 a.m. to 7:00 p.m., excluding holidays.
Buckeye is closed on these holidays:

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

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

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

Ohio Consumer Hotline: 1-800-324-8680
TTY: 1-800-292-3572

PCP's Name: ______________________________

PCP's Phone #: ______________________________

PCP's After-Hours #: ______________________________

Your Child's PCP's Name: ______________________________

Your Child's PCP's Phone #: ______________________________

Your Child's PCP's After-Hours Phone #: ______________________________

Your Pharmacy: ______________________________

Pharmacy's Phone #: ______________________________

Your Dentist: ______________________________

Dentist's Phone #: ______________________________

Welcome to Buckeye Health Plan

Welcome to Buckeye Health Plan (Buckeye), a subsidiary of Centene Corporation. You are now a member of a healthcare plan, also known as a managed care organization (MCO). Buckeye Health Plan provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, and children, older adults, and individuals with disabilities

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

It is important to remember that you must receive services covered by Buckeye from facilities and/or providers on Buckeye's network. See pages 13 for information on services covered by Buckeye.
The only time you can use providers that are not on Buckeye's network is for:

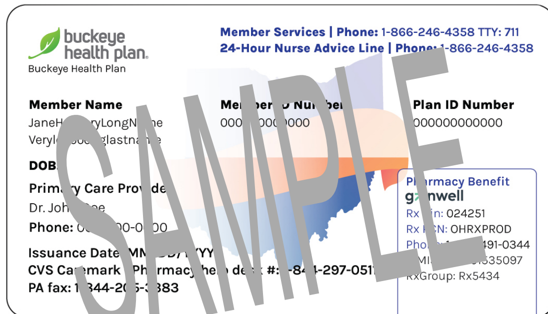
- Emergency services
- Federally qualified health centers/rural health clinics
- Certified nurse midwives or certified nurse practitioners
- Qualified family planning providers
- Ohio Department of Mental Health and Addiction Services (MHAS) certified
- Community Mental Health Centers and treatment centers or
- Ohio Department of Alcohol and Drug Addiction Services certified treatment centers.
- An out-of-network provider that Buckeye has approved you to see

You can request a printed Provider directory by calling the Member Services department or by returning the postcard you received with your new member letter and member identification (ID) card. The Provider Directory lists all of our network providers as well as other non-network providers you can use to receive services. You can also visit our website at BuckeyeHealthPlan.com to view up to date provider network information or call Member Services at 1-866-246-4358, TTY: 711, Monday - Friday, 7:00 a.m. to 7:00 p.m., for assistance.

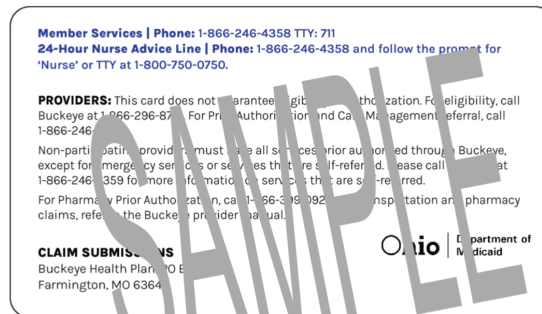
Identification (ID) Cards

You should have received a Buckeye membership ID card. Each member of your family who has joined Buckeye will receive their own card. These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of Buckeye. You will not receive a new card each month as you did with the Medicaid card.

If you are pregnant, you need to let Buckeye know. You must also call when your baby is born so we can send you a new ID card for your baby.



(ID Card Front)



(ID Card Back)

ALWAYS KEEP YOUR ID CARD(S) WITH YOU

You will need your ID card each time you get medical services. This means that you need your Buckeye ID card when you:

- See your primary care provider (PCP).
- See a specialist or other provider.
- Go to an emergency room.
- Go to an urgent care facility.
- Go to a hospital for any reason.
- Get medical supplies.
- Get a prescription.
- Have medical tests.

Call your Buckeye Member Services as soon as possible at 1-866-246-4358 (TTY 1-800-750-0750) if:

- You have not received your card(s) yet.
- Any of the information on the card(s) is wrong.
- You lose your card(s).
- You have a baby.

New Member Information

If you were on Medicaid fee-for-service the month before you became a Buckeye member and have healthcare services already approved and/scheduled, it is important that you call member services *immediately* (today or as soon as possible). In certain situations, and for a specified time period after you enroll, we may allow you to receive care from a provider that is not a Buckeye panel provider. Additionally, we may allow you to receive services that were authorized by Medicaid fee-for-service. **However, you must call Buckeye before you receive the care**. If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call member services if you have the following services already approved and/or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

After you enroll, Buckeye will tell you if any of your current medications require prior authorization that did not require authorization when they were paid by Medicaid fee-for- service. It is very important that you look at the information Buckeye provides and contact your Buckeye's member services if you have any questions. You can also look on Buckeye's website to find out if your medication(s) require prior authorization. You may need to follow up with the prescriber's office to submit a prior authorization request to Buckeye if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to Buckeye and it is approved.

Services & Benefits

Services Covered by Buckeye

As a Buckeye Health Plan member, you will continue to receive all medically necessary (medically-necessary means you need the services to prevent, diagnose, or treat a medical condition.)
Medicaid-covered services at no cost to you.

Buckeye covers all medically-necessary Medicaid-covered services.

- Acupuncture for pain management of headaches and lower back pain
- Ambulance and ambulette transportation
- Behavioral Health Services (including mental health and substance use disorder treatment services)
- Certified nurse midwife services
- Certified nurse practitioner services
- Chiropractic (back) services
- Dental services (includes two child and adult periodic oral exams and cleanings per year, more than what is available with fee-for-service Medicaid)
- Developmental therapy services for children aged birth to six years
- Diagnostic services (x-ray, lab)
- Doula services
- Durable medical equipment (breast pump, breast milk storage bags, walking aid, blood pressure)
- Emergency services
- Family planning services and supplies
- Federally Qualified Health Center (FQHC) and/or Rural Health Clinic (RHC) services
- Free Standing Birth Center services at a free-standing birth center (call member services for qualified centers)
- Home health services
- Hospice care (care for terminally ill, e.g., cancer patients)
- Inpatient hospital services
- Medical supplies
- Nursing facility services for a short-term rehabilitative stay (call member services for available providers; ODM may determine return to fee for service Medicaid)
- Obstetrical (maternity care - prenatal and postpartum including at risk pregnancy services) and gynecological services
- Outpatient hospital services
- Pharmacist services: provider-administered drugs (all other pharmacy services are covered by ODM’s contracted Single Pharmacy Benefit Manager (SPBM))
- Physical and occupational therapy

- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Preventive mammogram (breast) and cervical cancer (pap smear) exams
- Primary care provider services
- Private duty nursing services
- Renal dialysis (kidney disease)
- Respite services for Supplemental Security Income (SSI) members under the age of 21, as approved by CMS within the applicable 1915(b) waiver and as described in OAC rule 5160-26-03
- Screening and counseling for Obesity
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services
- Speech and hearing services, including hearing aids
- Telehealth Services (call member services for available providers)
- Vision (optical) services, including expanded selection of eyeglasses and contact lenses (more than what is available with fee-for-service Medicaid)
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well-adult exams

If you must travel 30 miles or more from your home to receive covered healthcare services, Buckeye will provide transportation to and from the provider's office. Buckeye also covers all necessary transportation by ambulance or wheelchair van, regardless of distance. Please contact Member Services 1-866-246-4358 at least 48 hours (two business days) in advance for assistance. In addition to the transportation assistance that Buckeye provides, members can still receive assistance with transportation for certain services through the local county department of job and family services Non-Emergency Transportation (NET) program. Call your county department of job and family services for questions or assistance with NET services.

Buckeye covers all medically necessary Medicaid-covered services, including the following:

- Primary care provider services. Members can see any covered PCP for primary covered services, including:

1. Yearly well-adult exams.
2. Shots/immunizations.
3. Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source.
4. HEALTHCHEK: Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21 years. These important exams make sure children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15,

18, 24, and 30 months of age. After that, children should have at least one exam per year or as indicated by the most recent version of the "Recommendations for Preventative Pediatric Health Care," published by Bright Futures/American Academy of Pediatrics.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental, and mental health exams, in addition to other care to treat physical, mental, or other problems or conditions discovered during the exam. Healthchek covers most tests and treatment services. If a test or service is not covered, it will require prior authorization."

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

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

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Some services may require a referral from your PCP or prior authorization by Buckeye. Also, for some EPSDT items or services, your provider may request prior authorization for Buckeye to cover things that have limits or are not covered for members over age 20. Please see page 15 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 years who have special health care needs. Please see page 24 to learn more about the care management services offered by Buckeye. You can obtain Healthchek services by calling your PCP's or dentist's office and scheduling an appointment. Make sure you tell them it is for Healthchek. If you would like more information

about the Healthchek program, or if you need assistance with accessing care for covered services, making an appointment with a provider, getting transportation, or prior authorization, please contact Buckeye's Member Services department at 1-866-246-4358 (TTY 1-800-750-0750).

Please see the form in this member packet you will need to fill out and send back to Buckeye Health Plan (paid postage included). We will use the information to provide services to help your family stay healthy.

Self-referred services are services that you may access without permission from your Primary Care Provider or from Buckeye. You may self-refer to a Buckeye provider for the following services:

- Obstetrical (OB) and/or gynecological services, including:
  - Maternity care for prenatal and postpartum, including at-risk pregnancy services
  - Preventive mammogram (breast) and cervical cancer (pap tests) exams
- Chiropractor
- Podiatry (Foot) Care
- Certified Nurse Midwife
- Routine Dental Care
- Routine Vision (Optical) Services, including eyeglasses
- Certified Nurse Practitioner
- Urgent Care Centers
- Specialist services
- Regular X-rays and lab (participating specialists may also send you for diagnostic tests)
- Outpatient hospital services (some surgical procedures may require prior authorization)
- Clinic services
- Health education
- Services for children with medical handicaps (Title V)
- Renal dialysis (kidney disease)
- Non-emergency wheelchair van transportation

You may self-refer to any provider for the following:

- Emergency services, including ambulance transportation (see page 18).
- Family planning services and supplies from a Qualified Family Planning Provider (listed in the Provider Directory).
- Care at Federally Qualified Health Center or Rural Health Clinic (listed in the Provider Directory).

The following are services that require a PCP referral and prior authorization from Buckeye:

- MRIs
- MRAs
- Bariatric surgery
- Pain Management
- PET Scans
- CAT Scans
- Cardiac Nuclear Scans
- Nursing facility services for a short-term rehabilitative stay
- Home healthcare
- Hospice care (care for terminally ill, for example, cancer patients)
- In-patient hospital services (emergency admissions do not require a referral or prior authorization)
- Medical supplies (some diabetic supplies for insulin and blood glucose monitoring do not require authorization)
- Durable Medical Equipment
- Speech and hearing services, including hearing aids
- Physical, Occupational and Speech Therapy AFTER the first 30 visits
- Non-routine dental care (for example, surgery)
- Non-routine vision (optical) services (for example, surgery)
- Non-emergency ambulance and ambulette transportation
- Plastic and reconstructive surgeons
- Developmental therapy services for children aged birth to six years
- Genetic Testing (prenatal, cancer screening, testing for children with developmental delays)

Out-of-Network Services

Coverage for out-of-network services are available when Buckeye Health Plan is unable to provide a necessary covered service in an adequate and timely manner.

New Technology

Buckeye wants to make sure you have access to the most up-to-date medical care. We have a team that watches for advances in medicine. This may include new medicine, tests, surgeries or other treatment options. The team checks to make sure the new treatments are safe. We will tell you and your doctor about new services covered under your benefits.

Behavioral Health Services

(including Mental Health and Substance Use Disorder Treatment Services)

Mental health and substance use disorder treatment services are available through the plan. These services include:

- Medical Services
- Medication-Assisted Treatment for Addiction
- Psychological Testing
- Diagnostic Evaluation and Assessment
- Psychotherapy and Counseling
- Crisis Intervention
- Mental Health Services Including Therapeutic Behavioral Service, Psychosocial Treatment for Adults and Intensive Home-Based Treatment for Children/Adolescents.
- Substance Use Disorder Treatment Services including Case Management, Peer Recovery Support, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Withdrawal Management
- Opioid Treatment Program Services
- Behavioral Health Nursing Services

In addition to these services, two new services are also available: Assertive Community Treatment and Intensive Home-Based Treatment.

If you need mental health and/or substance use disorder treatment services Buckeye's contracted mental health providers are listed in our Provider Directory, and can be found on our website at BuckeyeHealthPlan.com. You can also call member services at 1-866-246-4358 for assistance finding providers in your area.

The State of Ohio permits MCOs to develop and implement programs to assist certain members receiving medications that are not medically necessary to establish and maintain a relationship with their provider and/or pharmacy to coordinate treatment. Members selected for Buckeye's program will be provided additional information and notified of their state hearing rights, as applicable.

Members who are enrolled into the Coordinated Services Plan (CSP) program will have restrictions upon the physicians and pharmacies they may use for controlled substances, except for emergency situations. Members will also have the ability to change designated providers according to the policy.

OhioRISE

OhioRISE (Ohio Resilience through Integrated Systems and Excellence) is a Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved in multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health and addiction, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are provided in-home or in the young person's community.

Children and youth who may benefit from OhioRISE:

- Have multiple needs that result from behavioral health challenges.
- Have multisystem needs or are at risk for deeper system involvement.
- Are at risk of out-of-home placement or are returning to their families from out-of-home placement.

An individual who is enrolled in the OhioRISE program has their physical health services covered by managed care organizations (MCO) or fee-for-service (FFS) Medicaid.

OhioRISE Eligibility:

A child and youth may be eligible for OhioRISE if they:

- Are enrolled for Ohio Medicaid.
- Are under the age of 21, and
- Need significant behavioral health treatment as identified by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment, or
- Are in a hospital for mental health or substance use needs.

OhioRISE Services

In addition to the behavioral health services already available through Medicaid, OhioRISE offers the following services:

- **Care Coordination** – Assistance with planning support and care for a child or youth's behavioral health needs. Their care coordinator through their managed care organization (MCO) can also be part of this process.
- **Intensive Home-Based Treatment (IHBT)** – Intensive, short-term services within a child or youth's home to help stabilize and improve their behavioral health.
  Behavioral Health Respite – Short-term relief to the primary caregivers of a child or youth who is in a home or community-based environment.
- **Primary Flex Funds** – $1,500 in a 365-day period to purchase certain resources that address a specific need for a child or youth.
- **Psychiatric Residential Treatment Facility (PRTF)** – Facilities, other than hospitals, that provide intensive psychiatric residential treatment services to individuals ages 20 or younger.

- **Mobile Response and Stabilization Services (MRSS)** – Immediate behavioral health services for children/youth in crisis. MRSS helps to ensure children and youth receive urgent, necessary care in their homes and communities. This service is also provided through Medicaid managed care organizations (MCO) and fee-for-service (FFS) Medicaid.

CANS Assessments

To have a child or youth assessed for OhioRISE, contact [MCO and contact information]. We will help find a CANS assessor in the child or youth's community to have the CANS assessment completed.

OhioRISE Contact Information

For more information on OhioRISE, contact Buckeye Health Plan 1-866-246-4358 (TTY 1-800-750-0750) or Aetna OhioRISE Member Services at (833) 711-0773 (TTY: 711).

Buckeye's Additional Services and Benefits Available to All Members

Unless otherwise noted, contact Buckeye's Member Services at 1-866-246-4358 (TTY 1-800-750-0750), to get the services listed below. Member Services hours are Monday through Friday, 7 a.m. to 7 p.m. excluding holidays listed on page 5. You can also call Member Services for assistance with Grievances and Appeals; if you receive a bill for services from a provider; need help finding a provider or changing your Primary Care Provider; need language assistance; or need help accessing covered services. We are here to answer all of your questions and address any concerns you might have. Buckeye offers the following extra services and benefits to members.

Start Smart For Your Baby®

The Start Smart for Your Baby program is for women who are pregnant or just had a baby. We are here to assist you during and after your pregnancy. We provide support in a variety of ways to make things less stressful for you during this important time. Our goal is for you to have a healthy pregnancy and give your baby the best possible start to life.

This program is FREE and you can even earn rewards for going to your doctor visits. You should see your doctor as soon as you think you are pregnant. Early and regular doctor visits are important to the health of your baby.

This program is for you if:

- You are pregnant or thinking about becoming pregnant.
- You have a higher risk of preterm birth due to smoking, alcohol use, drug use, depression or a previous preterm birth.
- You do not want to get pregnant but are sexually active.
- You have questions or need help with women's health issues.

This program provides:

- Doctor visits at no cost. See your doctor as soon as you think you are pregnant. Early & regular doctor visits are important to the health of both the member & their baby.
- Help finding a doctor or hospital and setting up doctor appointments.
- Mental health support and services.
- A nurse who is specially trained to meet your needs.
- Breastfeeding support and resources.
- Assistance with quitting smoking, alcohol or drugs.
- Help finding community resources.

First steps for you to take:

If you are pregnant, please let us know by completing a Notification of Pregnancy (NOP).

Here's how

1. Go online and log into your member account;
2. Fill out the NOP paper given or sent to you by us;
3. Or, call us at 1-866-246-4358.

If you are not pregnant, call one of our nurses at 1-866-246-4358 and ask to speak with a "Start Smart nurse." Want to know more? Call us at 1-866-246-4358.

- Pregnancy - $100 (For the 3rd, 6th, and 9th prenatal visit)
- Postpartum - $75 (Visit must be 7 – 84 days after delivery)
- Infant Well Visit - $150 (Must complete 6 visits in the first 15 months of life)
- 15- to 30-months reward $50 ($25 x 2 visits)

We have many ways to help you have a healthy pregnancy. But before we can help, we need to know you are pregnant. Please call us at 1-866-246-4358 (TTY 1-800-750-0750) as soon as you learn you are pregnant. We will set up the special care you and your baby need.

My Health Pays® – Rewards Program

Earning rewards is easy! When you make certain healthy choices, reward dollars will be put on your My Health Pays® rewards card. The rewards are added approximately two weeks after we receive the claim for the healthy behavior. If it's your first reward, a card will be mailed to you. Keep the card after you use it and as you earn more rewards, they will be added to this card.

Earn Rewards by completing the following healthy activities:

$25 for getting an annual flu vaccine (one per flu season September – April, age 6 months and up)

$25 for getting child immunizations (age 0-2)

$25 for completing a lead screening (age 0-2)

$75 for an annual well care visit (age 3-11)

$50 for an annual well care visit (age 12 to 21)

$50 for an annual well care visit (age 21+)

$50 for an annual breast cancer screening (females age 50-74)

$50 for an annual cervical cancer screening (females age 21-64)

$75 for annual comprehensive diabetes care - must complete all of the following once in the calendar year: HbA1c test, kidney screening and retinopathy screening (dilated eye exam).

$25 for completing your Health Risk Assessment

$25 for completing your HPV vaccination (2 vaccinations on or between 9 and 13 years. Reward upon completion of both vaccinations.)

Pregnancy and infant well-care:

$100 for completing a Notification of Pregnancy (NOP) form within the first trimester.*

OR

$25 for completing a Notification of Pregnancy (NOP) form within the second trimester if not completed in the first trimester. (Log into the Secure Portal to access the NOP form.)

$75 for a postpartum doctor visit between 7-84 days after delivery.

$25 Infant Well Visit (16-30 Months). 2 visits between 16 months and 30 months for $25/visit ($50 total).

$100 Infant Well Visit (0-15 Months). Complete 6 visits before 15 months.

(These visits are recommended at 3-5 days old, before 30 days old, and at 2, 4, 6, 9, 12 and 15 months old.)

Log into your online member account for additional info on where to spend your reward dollars and which items can be purchased with your card.

Transportation

Buckeye provides round trip coverage for covered services 30+ miles away*. **In addition, Buckeye offers up to 20 round-trip visits (40 one-way trips) per member per 12-month period to covered healthcare/dental appointments, WIC appointments, and redetermination appointments with your Ohio Dept of Job and Family Services (ODJFS) caseworker.***

If you must travel 30 miles or more from your home to receive covered health care services, Buckeye will provide transportation to and from the provider's office. Buckeye also covers all necessary transportation by ambulance or wheelchair van, regardless of distance.

Members can call Member Services directly at 1-866-246-4358 to schedule transportation. If transportation is needed for an urgent medical appointment, we will arrange for a direct pick-up, without waiting 48 hours (if verified with your doctor).

You can get a ride—at no cost to you—to all medical appointments including:

- Dental visits
- Prenatal care appointments
- Primary care office visits
- Childhood immunizations
- Specialist appointments
- Urgent care centers
- WIC appointments
- Redetermination (face-to-face) visits with caseworkers/CDJFS
- Lyft is available when another transportation provider is unable to fulfill a transportation request
- 5 round-trips or 10 one-way trips for food-related travel (such as trips to a grocery store or farmers market).

Buckeye does not provide transportation for emergency services. If you have an emergency, call 911 or go to the nearest emergency room right away. If you are not sure whether you need to go to the emergency room, call your PCP or our 24-Hour Nurse Advice Line, Buckeye's Health Information Line at 1-866-246-4358 (TTY at 1-800-750-0750). If healthcare/dental appointments are needed beyond 1 5 round-trip (30 one-way) per member per 12-month period, you may contact the ODJFS about assistance.

Vision Benefits

To keep your eyes healthy, Buckeye offers these benefits for you and your family:

- Buckeye offers annual eye exams for children and adults.
- Eyewear (new glasses) are provided annually for children under the age of 21 and adults age 60 and over. Eyewear for members age 21 through 59 is provided every two years.
- Buckeye will provide $50 per year toward the purchase of contact lenses for children up to age 21 and adults 60 and older. $50 every two years for members 21-59 years of age.
- Buckeye offers $50 per year toward the contact lens fitting fee for children up to age 21 and adults age 60 and older. This is available every two years for adults age 21-59.
- Fee-for-service Medicaid does not cover contacts. Both contacts and glasses may not be obtained in the same year (or in the same two years for adults age 21-59).

Dental Benefits

Buckeye offers these advantages for your dental care:

- Two periodic oral exams and cleanings per year.
- Extractions and fillings.
- Braces covered under the age of 21.
- Partials, dentures, crowns (prior authorization is required).
- No copayments for dental services.

Respite

Respite services are services that provide short-term, temporary relief to an informal unpaid caregiver of a member under the age of 21 and those eligible of Supplemental Security Income (SSI) to support and preserve the primary caregiving relationship. Caregivers should contact the member's Buckeye care manager to arrange this benefit.

24-Hour Nurse Advice Line

Buckeye's 24-Hour Nurse Advice Line is staffed with Registered Nurses 24-hours-a-day, every day of the year and is your source for health information. Buckeye Nurses have spent lots of time caring for people. Now they are ready and eager to help you.

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

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

Not sure if you need to go to the Emergency Room or Urgent Care Center? Sometimes you may not be sure if you need to go to the Emergency Room or Urgent Care Center. Call the Nurse Advice Line. A nurse can assist you in knowing if it is an emergency or if it can wait. Emergency services are services for a medical problem that is so serious that it must be treated right away by a doctor.

Asthma Program

If you have a child with asthma, we have an Asthma Management Program that can help you manage your child's asthma better. Asthma is a disease that makes it hard to breathe. People with asthma:

- Are often short of breath
- Have a tightness in their chest
- Make a whistling sound when they breathe
- Cough a lot, especially at night

While asthma cannot be cured, it can be controlled. If your child has asthma, our program will help you:

- Identify things that cause an asthma attack
- Know when an asthma attack is occurring soon enough to prevent serious complications
- Get the right medicine and devices to prevent an attack
- See your child's doctor for treatment

Please call our Asthma Care Manager at 1-866-246-4359 (TTY 1-800-750-0750) if your child has asthma. Be sure to call if your child:

- Has been in the hospital for asthma during the past year
- Has been in the Emergency Room two or more times in the past six months for asthma
- Has been in the doctor's office three or more times in the past six months for asthma
- Takes oral steroids for asthma

Member Connections

We have a special program to connect you to quality healthcare and social services. It's called Member Connections. Our Member Connections outreach representatives will talk to you on the phone when you call 1-866-246-4358 (TTY 1-800-750-0750), send you information in the mail, and visit your home if you would like for them to come.

They will be glad to talk to you about:

- How to choose a doctor
- How to change doctors
- Covered healthcare services
- How to use your healthcare services
- How to get medical advice when you can't get your doctor
- Explain the difference in emergency and non-emergent care
- How to live a healthy life
- How to get immunizations and health screenings
- Any other healthcare service problem you may have

Member Connections outreach representatives can also help connect you to community social services if you need food, housing, clothing, utility services, etc. To reach Member Connections, call 1-866-246-4358 (TTY 1-800-750-0750).

Healthcare Reminders

Buckeye periodically sends postcards and text messages to members reminding them to schedule important healthcare appointments for things such as immunizations (shots), dental visits, and mammography and lead screenings.

Member Newsletters

Buckeye mails two issues of its quarterly newsletter, Healthy Moves, to its members and posts all four issues on the Buckeye web site. These newsletters include information about program benefits, as well as articles about health and wellness topics.

Care Management

Buckeye's **Care Manager** serves as a single point of contact for members when longer-term coordination needs are identified. Buckeye's Care Managers include licensed registered nurses, counselors and social workers that have clinical expertise to coordinate care and help members achieve their health care goals.

Buckeye's **Care Guide** serves as a single point of contact for members when short-term coordination needs are identified. Buckeye's Care Guides provide assistance to members for primarily non-health care related needs, connecting to a primary care provider, and short-term care needs following an emergency department visit.

Buckeye's **Care Coordination Program** provides care continuity to all of our members through a person-centered approach that aims to support our member's goals and coordinate care between the health care providers. Our Care Coordination Program identifies and addresses physical, behavioral, and psychosocial (non-medical) needs of members by preserving existing care relationships between members and local care coordination entities. Our Care Coordination strategy encompasses a broad range of activities, including short-term assistance to meet care gaps to longer-term, intensive care management for members with the most intense needs. Care coordination is:

- Member focused and inclusive of the member
- Conducted in collaboration with providers, community agencies, as well as members' natural support systems.
- Eligible for all members for short- and longer-term needs
- Aimed to keep members heathy by ensuring care is safe, appropriate, and effective.

Buckeye offers care management services that are available to children and adults with special health care needs. **Our care management program helps members learn more about their health concerns such as:**

- Asthma
- Severe cognitive and/or developmental limitation
- Diabetes
- Transplants
- Congestive heart failure (CHF)
- High-risk or high-cost substance abuse disorder
- Coronary artery disease (CAD)
- Frequent admissions or ED room visits
- Non-mild hypertension (high blood pressure)
- High risk pregnancies
- Chronic obstructive pulmonary disease (COPD)
- Premature babies
- HIV/AIDS
- Children with special health care needs
- Severe mental illness

Assistance is available for non-medical needs, including but not limited to: housing, food insecurity, transportation, financial, legal, employment, education/ schooling, durable medical equipment, and much more.

Mental and Behavioral Health

- Individual, group and family counseling sessions for mental, behavioral health and substance use disorders.
- Psychological and developmental testing.
- Medication Management.
- Electroconvulsive therapy (ECT).

The program is designed for members to have assistance from care managers to help them improve or maintain good health, and assist in arranging services they may need to manage their health. The goal of our program is to work together in developing a plan of care to help our members become more independent in meeting their healthcare needs. Please call Buckeye's Member Services department at 1-866-246-4358 (TTY 1-800-750-0750) if you would like more information about BuckeyeCare, our care management program.

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

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

Additionally:

- Buckeye staff, including nurses, care managers, and outreach workers may contact the member if a doctor has requested a phone call, if the member requests the phone call, or if Buckeye feels that care management services would be helpful to the member.
- Buckeye staff may ask the member questions to learn more information about his/her conditions(s).
- Buckeye staff will provide information to help a member understand how to care for his/her self and how to access services (including local resources).
- Buckeye staff will talk to the member's PCP and other service providers to coordinate care.
- Members should call Buckeye's Member Services department at 1-866-246-4358 (TTY 1-800-750-0750) if they have any questions about care management services or if they feel they would benefit from care management services.

Services Not Covered by Buckeye or Ohio Medicaid

Buckeye will not pay for services or supplies received that are not covered by Medicaid. If you have a question about whether a service is covered, please call member services at 1-866-246-4358 TTY (711) Monday through Friday 7a.m. to 7p.m.

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy)
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

Services Not Covered by Buckeye Unless Medically Necessary

Buckeye reviews applicable State regulations and will conducts medical necessity review, if needed.

Buckeye will review applicable OAC rules (e.g.5160-1-61) and conduct a medically necessity review if appropriate. If you have a question about whether a service is covered, please call member services at 1-866-246-4358 TTY (711) Monday through Friday 7a.m. to 7p.m.

Buckeye will not pay for the following services that are not covered by Medicaid **unless determined medically necessary:**

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
- This is not a complete list of the services that are not covered by Medicaid or Buckeye. If you have a question about whether a service is covered, please call the Member Services department at 1-866-246-4358 (TTY:711) Monday through Friday 7 a.m.- 7 p.m.

Telehealth

Telehealth is the direct delivery of health care to a patient via audio and/or video. Instead of coming into the office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost for Medicaid members to use telehealth and telehealth removes the stress of needing transportation services.

Medicaid members can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as prescribing medication(s).

Check with your healthcare provider to see if they offer telehealth.

Primary Care Provider

Choosing a Primary Care Provider (PCP)

Each member of Buckeye must choose a primary care provider (PCP) from Buckeye's provider directory. Your PCP is an individual physician, physician group practice, advance practice nurse or advance practice nurse group practice trained in family medicine (general practice), internal medicine, or pediatrics.

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

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

Changing Your PCP

If for any reason you want to change your PCP, you must first call the Member Services department to ask for the change. You may also change your PCP on line within the secure member portal. A member can change their PCP monthly. Please note, any changes to the selected PCP within the first month of membership will be effective the date of the request for the PCP change. If you request a PCP change after your first month of membership, the change will be effective on the first day of the next month.

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

For the names of the PCPs in Buckeye, you may look in your provider directory if you requested a printed copy, on our website at www.buckeyehealthplan.com, or you can call the Buckeye Member Services department at 1-866-246-4358 (TTY 1-800-750-0750) for help.

Emergency care

Out-Of-Area, After Hours, and Emergency Care

Out-Of-Area and After-Hours Care

If your PCPs office is closed or you are away from home anywhere in the United States, and you have a problem that is not an emergency, call your Buckeye PCP at the phone number listed on your ID card. You can also call 24 Hour Nurse Advice Line, 24 hours a day, seven days a week toll-free at 1-866-246-4358, (TTY 1-800-750-0750). A nurse will answer and help you determine what to do.

Medical care is available through Buckeye providers 24-Hour a day, seven days a week. After hours, your PCP's phone will be answered by either an answering service or an answering machine with specific instructions. Be sure to follow the machine's instructions. The answering service will have your PCP or the doctor who is covering for the PCP call you back. Tell them you are a Buckeye member and explain your problem. They will tell you what to do. You can also visit a contracted

Urgent Care Center listed in our Provider Directory or on our website at www.buckeyehealth.com, or you can call the Nurse Advice Line toll-free at 1-866-246-4358, (TTY 1-800-750-0750).

Emergency Services

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

Some examples of when emergency services are needed include:

- Chest pain
- Poisoning
- Broken arm or leg
- Severe bleeding
- Severe burns
- Sudden shortness of breath or difficulty breathing
- Miscarriage/pregnancy with vaginal bleeding

You do not have to contact Buckeye for an okay before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your primary care provider or the Buckeye Nurse Advice Line, at 1-866-246-4358, (TTY 1-800-750-0750). Your PCP or the Buckeye Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do.

Please note that you may self-refer to a Buckeye Urgent Care Center after hours if that facility is open at the time.

Remember, if you need emergency services:

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

Prescription Drugs

Please see page 58 for Prescription Drug information.
Appendix A: Ohio Single Pharmacy Benefit Manager (SPBM)

Buckeye members will use Gainwell, ODM's contracted SPBM, to fill prescriptions and will need to refer to the Gainwell member handbook for assistance.

Grievances and Appeals

How to let Buckeye know if you are unhappy or do not agree with a decision we made: Grievances and Appeals

If you are unhappy with Buckeye or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to give us your approval in writing. Buckeye wants to help. To contact us you can:

- Call the Member Services department at 1-866-246-4358 (TTY 1-800-750-0750), or
- Fill out the form in your member handbook, or
- Call the Member Services department to request they mail you a form, or
- Visit our website at www.buckeyehealth.com, or
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your Buckeye member ID card, and your address and telephone number in the letter so that we can contact you, if needed.

You should also send any information that helps explain your problem, such as the date and where the problem occurred.

Mail the form or your letter to:

Buckeye Health Plan
Appeals/Grievance Coordinator
4349 Easton Way, Suite 300
Columbus, OH 43219

Buckeye will send you something in writing if we make a decision to:

- deny a request to cover a service for you;
- reduce, suspend or stop services before you receive all of the services that were approved; or
- deny payment for a service you received that is not covered by Buckeye

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

- make a decision on whether to okay a request to cover a service for you, or
- give you an answer to something you told us you were unhappy about

If you do not agree with the decision or action listed in the letter, and you contact us within 60 calendar days to ask that we change our decision or action, this is called an appeal. The 60-calendar-day period begins on the day after the mailing date on the letter. Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action as a result of your appeal, we will notify you of your right to request a state hearing. You may only request a state hearing after you have gone through Buckeye's appeal process.

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

Grievances

If you contact us because you are unhappy with something about Buckeye or one of our providers, this is called a grievance. Buckeye will give you an answer to your grievance by phone (or by mail if we can't reach you by phone) within the following time frames:

- Two working days for grievances about not being able to get services
- Thirty calendar days for all other grievances except grievances that are about getting a bill for care you have received
- Sixty calendar days for grievances about getting a bill for care you have received
- If we need more time to make a decision for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter will also explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

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

Ohio Department of Medicaid Bureau of Managed Care P.O. Box 182709 Columbus, Ohio 43218-2709 1-800-605-3040 or 1-800-324-8680. TTY: 1-800-292-3572	**Ohio Department of Insurance** 50 W. Town Street 3rd Floor, Suite 300 Columbus, Ohio 43215 1-800-686-1526

State Hearings

A State Hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Buckeye Health Plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think Buckeye Health Plan did not make the right decision and Buckeye Health Plan will explain the reasons for making our decision. The hearing officer will listen and then decide who is right based on the rules and the information given.

Buckeye will notify you of your right to request a state hearing if:

- we do not change our decision or action as a result of your appeal
- a decision is made to reduce, suspend, or stop services before all of the approved services are received
- a decision is made to propose enrollment or continue enrollment in Buckeye's CSP program
- a decision is made to deny your request to change your Buckeye CSP program provider.

If you want a state hearing, you or your authorized representative must request a hearing within 90 calendar days. The 90-calendar day period begins on the day after the mailing date on the hearing form. You can also complete an online submission at:
https://hearings.jfs.ohio.gov/apps/SHARE/#_frmLogin
If your appeal was about a decision to reduce, suspend, or stop services before all of the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the Coordinated Services Program and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

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

To request a hearing, you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request via e-mail at bsh@jfs.ohio.gov. A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from Buckeye and a hearing officer from the Ohio Department of Job and Family Services. Buckeye will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules. If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888, for the local number.

Grievances/Appeals Form

If you wish to file a grievance/appeal, please contact Member Services at 1-866-246-4358 (TTY 1-800-750-0750). If you do not have access to a phone, you can complete this form or write a letter that includes the information requested below. The completed form or your letter should be mailed to:

Buckeye Health Plan
Appeals/Grievance Coordinator
4349 Easton Way, Suite 300
Columbus, OH 43219

Or fax to 1-866-719-5404 following the incident causing the complaint.

Please note: You must provide complete and accurate contact information below so Buckeye can contact you to work with you on resolving your issue.

Name of Member:____

Address of Member: ____

Phone number of Member: ____

Member MMIS Number: ____

Legal Guardian/Custodial Parent: ____

Has this issue been brought to the attention of a Buckeye employee before? _______________

If yes, when? _________________________ To whom? _________________________________

Nature of Complaint: (Please state all details relating to the incident in question, including names, dates, places, etc. Please attach additional sheets of supporting documentation about your grievance/appeal, if necessary.)

____

____

____

____

The section below will be completed by Buckeye. Resolution:

____

____

____

____

Representative: _______________________

Date:________________________________

Membership Termination

Loss of Medicaid Eligibility

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

Loss of Insurance Notice (Certification of Creditable Coverage)

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

Automatic Renewal of MCP Membership

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become a Buckeye member again.

Ending Your MCP Membership

As a member of a managed care plan, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month for your area. The Ohio Department of Medicaid notify you to tell you know when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care.

If you are thinking about changing to another health plan, you should learn about your choices, especially if you want to keep your current doctor(s). Remember, each health plan has its own list of doctors and hospitals that they will allow you to use. Each health plan also has written information that explains the benefits it offers and the rules that it has. If you would like written information about a health plan you are thinking of joining or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680; TTY 711. You can also find information about the health plans in your area by visiting the Medicaid Hotline website at www.ohiomh.com.

If you want to end your membership during the first three months of your membership or open enrollment month for your area you can call the Medicaid Hotline at 1-800-324-8680; TTY 711. You can also submit a request online by visiting the Medicaid Hotline website at www.ohiomh.com. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

Just Cause Membership Terminations

Sometimes there may be a special reason that you need to end your membership with a plan. This is called a "Just Cause" membership termination. Just cause requests apply to periods outside of open enrollment and the first three months of enrollment. Before you can ask for a just cause membership termination, you may first call Buckeye and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination at any time if you have one of the following reasons:

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

You may ask to change your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680; TTY 1-800-292-3572. The Ohio Department of Medicaid will review your request to change your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your current membership and the date your membership in the new plan begins. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to Keep in Mind If You Change Your Membership

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

1. Continue to use Buckeye Health Plan doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
2. If you chose a new MCP and have not received a member ID card before the first day of the month when you are a member of the new plan, call the Buckeye Health Plan Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680; TTY 1-800 292-3572.
3. If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.

4. If you have chosen a new MCP and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or x-ray scheduled and especially if you are pregnant.
5. If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Optional Membership

You have the option not to be a member of a managed care plan if:

- you are a member of a federally recognized Indian tribe, regardless of your age.
- you are an individual who receives home and community based waiver services through the Ohio Department of Developmental Disabilities.

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care plan, you can call the Medicaid Hotline at 1-800-324-8680 (TTY 1-800-292-3572). If someone meets the above criteria and does not want to be an MCP member, their membership will be ended.

Excluded from MCP Membership

Individuals that are not permitted to join a Medicaid MCP:

- Dually eligible under both the Medicaid and Medicare programs;
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, ICF-MR, or some other kind of institution); or
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.

  * If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Plan. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Plan.

If you believe that you meet any of the above criteria and should not be a member of a managed care plan, you must call the Medicaid Hotline at 1-800-324-8680 (TTY 1-800-292-3572). If you meet the above criteria, your MCP membership will be ended.

Can Buckeye End My Membership?

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

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

Membership Rights

Your Membership Rights

As a member of Buckeye, you have the following rights:

- To receive all services that Buckeye must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your healthcare unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless
- Buckeye has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or Buckeye must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See page 30 of this handbook for information.
- To be able to get all Buckeye written member information from Buckeye:
  - at no cost to you;
  - in the prevalent non-English languages of members in Buckeye's service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from Buckeye and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the healthcare provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See the pamphlet in your new member packet which explains about advance directives. You can also contact member services for more information.

- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on Buckeye's panel at least monthly. Buckeye must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that Buckeye, Buckeye's providers or the Ohio Department of Medicaid will not hold this against you.
- To know that Buckeye must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider on Buckeye's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on Buckeye's panel. If a qualified provider is not able to see you, Buckeye must set up a visit with a provider not on our panel.
- To get information about Buckeye from us.

To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services' Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

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

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

Membership Responsibilities

Your Membership Responsibilities

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

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

That includes the responsibility to:

- Work as a team with your provider in deciding what healthcare is best for you.
- Do the best you can to stay healthy.
- Treat providers and staff with respect.

Other Information

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

Ohio Department of Medicaid Bureau of Managed Care
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-605-3040 or 1-800-324-8680
TTY: 1-800-292-3572

You can also visit Ohio Department of Medicaid on the web at: www.medicaid.ohio.gov

- You can contact Buckeye to get any other information you want, including the structure and operation of Buckeye, and how we pay our providers.
- If you want to tell us about things you think we should change, please call the Member Services department at 1-866-246-4358 (TTY 1-800-750-0750).
- You have the right to make recommendations about Buckeye's Member Rights and Responsibilities policies.
- You have the right to ask Buckeye about how we evaluate new healthcare procedures and services that we cover as a benefit.
- You have the right to ask Buckeye about our reasons for the decisions we make about your healthcare.
- At Buckeye, your privacy is important to us. We will do all we can to protect your health records. By law, we must protect your health records and send you a Privacy Notice, which we have included at the end of this Handbook. The Privacy Notice tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to use those rights and who can see your health records. The notice does not apply to information that does not identify you. When we talk about your health records in the notice, it includes any information about your past, present or future physical or mental health while you are a member of Buckeye. This includes providing healthcare to you. It also includes payment for your healthcare while you are our member.

Accidental Injury or Illness (Subrogation)

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

Other Health Insurance (Coordination of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call the Member Services department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent then you need to call the Member Services department to give us the information. It is also important to call member services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

Privacy Notice

Buckeye Health 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 January 1, 2013

For help to translate or understand this, please call 1-866-246-4358.
Hearing impaired TTY 1-800-750-0750.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-866-246-4358.
(TTY 1-800-750-0750).

Interpreter services are provided free of charge to you.

Covered Entities Duties:

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

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

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

- The Uses and Disclosures
- Your Rights
- Our Legal Duties
- Other privacy practices stated in the notice

Updated notices will be on our website and in our Member Handbook. We will also mail you or email you a copy on requeUses and Disclosures of Your PHI:

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

- **Treatment**. We may use or disclose your PHI to a physician or other healthcare provider providing treatment to you. We do this to coordinate your treatment among providers.
  We also do this to help us with prior authorization decisions related to your benefits.
- **Payment.** We may use and disclose your PHI to make benefit payments for the healthcare services your received. We may disclose your PHI for payment purposes to another health plan, a healthcare provider, or other entity. **This is subject to the federal Privacy Rules. Payment activities may include:**
  - Processing claims
  - Determining eligibility or coverage 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

- **Appointment Reminders/Treatment Alternatives**. We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us. We may also use or disclose it to give you information about treatment alternatives. We may also use or disclose it for other health- related benefits and services. For example, information on how to stop smoking or lose weight.
- **As Required by Law.** If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information. We this when the use or disclosure complies with the law. This use or disclosure is limited to the requirements of the law. There could be other laws or regulations that conflict. If this happens we will comply with the more restrictive laws or regulations.

- **Public Health Activities.** We may disclose your PHI to a public health authority to prevent or control disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA). We can do this to ensure the quality, safety or effectiveness products or services under the control of the FDA.
- **Victims of Abuse and Neglect.** We may disclose your PHI to a local, state, or federal government authority. This includes social services or a protective services agency authorized by law to have these reports. We will do this if we have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings**. We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following;

  – An order of a court
  – Administrative tribunal
  – Subpoena
  – Summons
  – Warrant
  – Discovery request
  – Similar legal request

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

  – Court order
  – Court-ordered warrant
  – Subpoena
  – Summons issued by a judicial officer
  – Grand jury subpoena

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

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

We may also disclose your PHI to those who work in procurement, banking or transplantation of:

- Cadaveric organs
- Eyes
- Tissues

- **Threats to Health and Safety.** We may use or disclose your PHI if we believe, in good faith, that it is needed to prevent or lessen a serious or imminent threat. This includes threats to the health or safety of a person or the public.
- **Specialized Government Functions.** If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:
  - To authorized federal officials for national security
  - To intelligence activities
  - The Department of State for medical suitability determinations
  - For protective services of the President or other authorized persons
- **Workers' Compensation.** We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law. These are programs that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations.** We may disclose your PHI or if you are unable to respond or not present.

  This includes to a family member, close personal friend, authorized disaster relief agency, or any other person you told us about. We will use professional judgment and experience to decide if the disclosure is in your best interests. If it is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- **Research.** In some cases, we may disclose your PHI to researchers when their clinical research study has been approved. They must have safeguards in place to ensure the privacy and protection of your PHI.

Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data

We may get information related to your race, ethnicity, language, sexual orientation and/or gender identity. We protect this information as described in this notice. We may use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Create health education information
- Let the doctors know about your language needs
- Address health care disparities
- Let member facing staff and doctors know about your pronouns

We do not use this information to:

- Determine benefits
- Pay claims
- Determine your cost or eligibility for benefits
- Discriminate against members for any reason
- Determine health care or administrative service availability or access

Verbal Agreement to Uses and Disclosure Your PHI

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

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

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

- **Sale of PHI.** We will request written approval before we make any disclosure that is deemed a sale of your PHI. A sale of the PHI means we are getting paid for disclosing the PHI in this manner.
- **Marketing.** We will request your written approval to use or disclose your PHI for marketing purposes with limited exceptions. For example, when we have face-to-face marketing communications with you. Or, when we give promotional gifts of nominal value.
- **Psychotherapy Notes.** We will request written approval to use or disclose any of your psychotherapy notes that we may have on file with limited exception. For example, for certain treatment, payment or healthcare operation functions.

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

Your Rights

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

- **Right to Request Restrictions.** You have the right to ask for restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations. You can also ask for disclosures to persons involved in your care or payment of your care. This includes family members or close friends. Your request should state the restrictions you are asking for. It should also say to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request. We will not comply if the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or healthcare operations to a health plan when you have paid for the service or item out of pocket in full.
- **Right to Request Confidential Communications.** You have the right to ask that we communicate with you about your PHI in other ways or locations. This right only applies if the information could endanger you if it is not communicated in other ways or locations. You do not have to explain the reason for your request. However, you must state that the information could endanger you if the change is not made. We must work with your request if it is reasonable and states the other way or location where 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 ask that we give copies in a format other than photocopies. We will use the format you ask for unless we cannot practicably do so. You must ask in writing to get access to your PHI. If we deny your request, we will give you a written explanation. We will tell you if the reasons for the denial can be reviewed. We will also let you know how to ask for a review or if the denial cannot be reviewed.
- **Right to Change your PHI.** You have the right to ask that we change your PHI if you believe it has wrong information. You must ask in writing. You must explain why the information should be changed. We may deny your request for certain reasons. For example, if we did not create the information you want changed and the creator of the PHI is able to perform the change. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision. We will attach your statement to the PHI you ask that we change. If we accept your request to change the information, we will make reasonable efforts to inform others of the change. This includes people you name. We will also make the effort to include the changes in any future disclosures of that information.
- **Right to Receive an Accounting of Disclosures.** You have the right to get a list of times within the last 6 year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, healthcare operations, or disclosures you authorized and certain other activities. If you ask for this more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will give you more information on our fees at the time of your request.

- **Right to File a Complaint.** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us. You can also do this by phone. Use the contact information at the end of this Notice. You can also submit a written complaint to the U.S. Department of Health and Human Services (HHS). See the contact information on the HHS website at www.hhs.gov/ocr. If you request, we will provide you with the address to file a written complaint with HHS. WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- **Right to Receive a Copy of this Notice.** You may ask for a copy of our Notice at any time.

  Use the contact information listed at the end of the Notice. If you get this Notice on our website or by email, you can request a paper copy of the Notice.

Contact Information

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

Buckeye Health Plan
Attn: Privacy Official
4349 Easton Way, Suite 300
Columbus, OH 43219
1-866-246-4358 (TTY: 1-800-750-0750)

Advance Directives

"Using Advance Directives to state wishes about your medical care"

Many people today worry about the medical care they would get if they became too sick to make their wishes known.

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

You Have a Choice

A growing number of people are acting to make their wishes known. You can state your medical care wishes in writing while you are healthy and able to choose.

Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes down in writing.

This information explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care.

This information also explains how you can state your wishes about the care you would want if you could not choose for yourself.

This information does not contain legal advice, but will help you understand your rights under the law.

For legal advice, you may want to talk to a lawyer. For information about free legal services, call 1-800-589-5888 Monday through Friday, 8:30 a.m. - 5 p.m.

Advance Directives

What is the difference between a Durable Power of Attorney for medical care and a Living Will?

Your Living Will explains, in writing, the type of medical care you would want if you couldn't make your wishes known.

Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.

If I have a Durable Power of Attorney for medical care, do I need a Living Will, too?

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

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

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

Can I change my advance directive?

You can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio's law (effective October 10, 1991). You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

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

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also (see below).

What are my rights?

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

What if I'm too sick to decide? What if I can't make my wishes known?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want.

Under Ohio law, you have the right to fill out a form while you're able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order.

You fill out an advance directive while you're able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

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

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

Who can fill out an advance directive?

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

Do I need a lawyer?

No, you don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

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

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

Living Will

This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your own wishes known. You can state when you would or would not want food and water supplied artificially.

How does a Living Will work?

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

- In a coma that is not expected to end, OR
- Beyond medical help with no hope of getting better and can't make your wishes known, OR
- Expected to die and can't make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your own wishes.

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

Do-Not Resuscitate Order

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

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

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

Durable Power of Attorney

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

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

Who should I choose?

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

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

The form takes effect only when you can't choose your care for yourself, whether for a short or long while.

This form allows your relative or friend to stop life support only in the following circumstances:

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

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

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

Estate Recovery

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

Other Matters to Think About

What about stopping or not using artificially supplied food and water?

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

- IF you are expected to die and can't make your wishes known
  AND your Living Will simply states you don't want life-support methods used to lengthen your life,
  THEN artificially supplied food and water can be stopped or not used.
- IF you are expected to die and can't make your wishes known,
  AND you don't have a Living Will
  THEN Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.
- IF you are in a coma that is not expected to end,
  AND your Living Will states you don't want artificially supplied food and water
  THEN artificially supplied food and water may be stopped or not used.
- IF you are in a coma that is not expected to end,
  AND you don't have a Living Will,
  THEN Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.
  However, he or she must wait 12 months and get approval from a probate court.

By filling out an advance directive, am I taking part in euthanasia or assisted suicide?

No, Ohio law doesn't allow euthanasia or assisted suicide.

Where do I get advance directive forms?

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

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

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Durable Power of Attorney for medical care, give that person a copy.

Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends about what you have done. Don't just put these forms away and forget about them.

Organ and Tissue Donation

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

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

- You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card, or
- You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

Managed Care Terminology

Appeal: a member's request for the Buckeye Health Plan/OhioRISE to review an adverse benefit determination.

Benefits: Healthcare services that are covered by Buckeye Health Plan.

Co-Payment: a fixed amount a member pays for a covered health care service.

Durable Medical Equipment: equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

Emergency: Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

Emergency Room Care: medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency Services: covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care

professionals or health care facilities not under employment or under contractual arrangement with the Buckeye Health Plan/OhioRISE.

Excluded Services: health services that the Buckeye Health Plan/OhioRISE does not pay for or cover.

Grievance: a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

Habilitation Services and Devices: services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Healthchek: A program of comprehensive preventive health services available to Medicaid consumers from birth until the day before age 21. The program is designed to maintain health by providing early intervention to discover and treat health problems.

Health Insurance: A contract that requires Buckeye Health Plan/OhioRISE to pay some or all of your health care costs in exchange for a premium.

Home Health Care: services that include home health nursing, home health aide services and skilled therapies.

Hospice Services: a public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals. (5160-56-01(V)).

Hospitalization: care in a hospital that requires admission as an inpatient.

Hospital Outpatient Care: diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital.

Identification Card (ID card): A card for each Buckeye member that is needed by your doctor's office before you can receive care.

Medically Necessary: criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

MHA: Ohio Department of Mental Health and Addiction Services.

Network: Buckeye Health Plan/OhioRISE's contracted providers available to the Buckeye Health Plan/OhioRISE's members.

Non-Participating Provider: any provider with an ODM provider agreement who does not contract with an Buckeye Health Plan/OhioRISE but delivers health care services to an Buckeye Health Plan/OhioRISE's members.

Participating Provider: any provider, group of providers, or entity that has a network provider contract with the Buckeye Health Plan/OhioRISE in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the Buckeye Health Plan/OhioRISE's provider agreement or contract with ODM.

Physician Services: (L) "Practitioner of physician services": are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants. (5160-2-02(L)).

Plan: (S) "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. (5160-26-01(S)).

Post-stabilization care services: covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R.422.113 to improve or resolve the member's condition

Preauthorization: a decision by the Buckeye Health Plan/OhioRISE that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Premium: "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM. (516026-01(NN))

Prescription Drug Coverage: drugs covered by the Single Pharmacy Benefit Manager (SPBM) that are dispensed to members for the use in a patient's resident, including a nursing facility or intermediate care facility for individuals with intellectual disabilities.

Prescription Drugs: simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care Physician or Provider: an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Ohio Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Ohio Administrative Code contracting with an Buckeye Health Plan to provide services as specified in rule 5160-26-03.1 of the Ohio Administrative Code.

Provider: a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to a Buckeye Health Plan members.

Referral: The process of your PCP recommending or requesting services for you before you can get them. Your PCP will call and arrange these services for you; give you written approval to take with you when you get the referred services; or just tell you what to do. In some cases, Buckeye may authorize a specialist to make referrals for you.

Rehabilitation Services and Devices: specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

Skilled Nursing Care: specific tasks that must, in accordance with Chapter 4723. of the Ohio Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

Specialist: a physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Urgent Care: care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Appendix A: Ohio Single Pharmacy Benefit Manager (SPBM)

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1.1 Corporate Identity

Gainwell Technologies is a company with over 50 years of proven experience, and a reputation for service excellence and unparalleled expertise. Gainwell does not operate under any other trade names or DBA. At Gainwell, everything we do focuses on people.

The mission at Gainwell is to empower clients through innovative technologies and solutions to deliver great health and human services outcomes.

You are now a member of our Single Pharmacy Benefits Manager (SPBM). Here at Gainwell, we believe you deserve quality pharmacy services and should receive the most up-to-date services that we can provide.

Online: https://spbm.medicaid.ohio.gov

Email: OH_MCD_PBM@gainwelltechnologies.com

If you suspect provider or consumer fraud, please contact our Fraud, Waste, and Abuse toll free tip line at **1-833-491-0344** (**TTY 1-833-655-2437**) and select the option to report Fraud, Waste, and Abuse concerns.

1.2 Available Services

Gainwell covers all Medicaid-covered, medically necessary prescription and over-the-count (OTC) medications. We use a preferred drug list (PDL) which is a list of drugs we prefer your provider prescribe. We may require your prescriber to submit a prior authorization request, which is where your prescriber would provide us additional information explaining why a specific medication and/or a certain dose or quantity of medication may be required.

The below services are available to you to support any additional needs you may have:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in alternative formats including braille and large print.

1.2.1 Preferred Drug List (PDL)

Gainwell uses a PDL which is a list of drugs we prefer your provider prescribes. You can find a copy of the PDL in the following locations:

- Under the Reference Material tab at: https://spbm.medicaid.ohio.gov
- Logging in to your Gainwell Member Portal at: https://spbm.medicaid.ohio.gov
- The Ohio Department of Medicaid pharmacy website at: https://medicaid.ohio.gov/stakeholders-and-partners/phm/unified-pdl
- A paper copy can be requested by calling Member Services at **1-833-491-0344** (**TTY 1-833-655-2437**)

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. Gainwell accepts prior authorization submissions via phone, fax, mail, web portal, or ePA. In these circumstances, your

provider will send an authorization request to the Gainwell Pharmacy Services team, where they will complete a clinical review of the medication your provider is requesting. Gainwell Pharmacy Services team will work closely with your prescriber to provide the best clinical decision. You will receive a letter in the mail with the outcome of the decision made.

If you do not agree with the decision that is made by Gainwell, you will be sent detailed information on how you can appeal the decision.

You have the option to call Member Services toll free at **1-833-491-0344** (**TTY 1-833-655-2437**) to obtain information regarding the PDL, medications that may require prior authorization, or to ask any medication related questions you may have. The PDL and a list of medications that require prior authorization are available for you to access online at: https://spbm.medicaid.ohio.gov. It is important that you and/or your prescriber reference the PDL and/or the list of medications that require prior authorizations each time you have questions, as these are documents that can change.

1.2.3 Pharmacy Utilization Management Strategies

The PDL will be used with each prior authorization review that is completed by the Gainwell Pharmacy Services team. When a prior authorization is required, Gainwell must approve the prescriber's request before you will be able to fill your medication at your preferred, in- network pharmacy. A prior authorization may be required if:

- A generic drug is available. The requested drug can be misused/abused.
- Other medications must be tried first.
- Quantity limits for the requested medication have been exceeded.
- The medication your provider has prescribed is not included on the PDL.

The PDL usually includes multiple medication options for treating a particular condition. These different drugs are referred to as "alternative" drugs and are just as effective as other drugs with no additional side effects or health problems.

Specific reasons your prescriber may be required to submit a prior authorization request include:

Step Therapy – In some cases, our plan requires you first try certain drugs to treat your medical condition.

Generic Substitution – This is where a pharmacy will be required to provide a generic drug in place of a brand-name drug when available. Generic drugs are just as safe and effective as brand name drugs and should be prescribed first.

Therapeutic Interchange – This is where you are unable to take a medication for reasons like an allergy, intolerance, etc., a medication might not work for you and your prescriber may write a prescription for a medication that is not on the approved drug list.

Specialty Medications – This is a review of a medication that is considered more complex for a specific disease and requires specific attention and handling during the prior authorization review process. For these medications, you may have to get them through a specialty pharmacy. Your prescriber will work with Gainwell Pharmacy Services to make sure you can obtain the medication you need as quickly as possible.

1.2.4 Excluded Services

Gainwell will not pay for the following categories that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for treatment of obesity.
- Drugs for treatment of infertility.
- Drugs for the treatment of erectile dysfunction.
- DESI drugs or drugs that may have been determined to be identical, similar, or related.
- Drugs that are eligible to be covered by Medicare Part D.
- Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03.
- Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence.

1.2.5 Additional Services

The Gainwell Pharmacy team can also assist you with the below services by calling our member help desk at **1-833-491-0344** (**TTY 1-833-655-2437**). You can also access this information on your member portal by logging in at https://spbm.medicaid.ohio.gov.

- Locating a pharmacy to fill the prescription you were given by your provider.
- Verifying you have active pharmacy coverage.
- Obtaining diabetic supplies covered through your pharmacy benefit. Obtaining durable medical equipment (DME) covered through your pharmacy benefit.

1.3 Requests for Appeals, Grievances, or State Hearings

Grievance

If you are unhappy with anything in relation to Gainwell Pharmacy Services or our providers, please contact us as soon as possible. This is called a grievance.

To contact us you can:

- Call member services at 1-833-491-0344 (**TTY 1-833-655-2437**) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below or online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter telling us you are unhappy. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail:
Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Once you contact Gainwell to submit your grievance, we will follow up with you by telephone, mail delivery, or other appropriate means with the below timeframes:

- Two (2) working days for grievances about not being able to get medications you need.
- Thirty (30) calendar days for all other grievances.

Appeal

If you receive a notice from us that you disagree with, you may ask for an appeal within sixty (60) calendar days after the date of the notice. Gainwell will provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If you believe fifteen (15) calendar days could seriously jeopardize your life, physical or mental health or ability to attain, maintain, or regain maximum function, contact Gainwell Member Services at the number listed below as soon as possible to expedite your review process. To request an appeal, you can:

- Call Member Services at **1-833-491-0344** (**TTY 1-833-655-2437**) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below, or complete online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter. Please be sure to include your first and last name, Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail:
Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

When submitting an appeal, please include the following information:

- Your name and Medicaid ID number on your card.
- Your prescriber's name.
- The reason you disagree with the outcome provided by Gainwell.
- Any documentation or information to support your request to have your decision overturned

Gainwell must provide you with an answer to your appeal within fifteen (15) calendar days from the date you contact us. If we do not change our decision, you will be notified in writing and will be provided your right to request a State hearing. You must complete the appeal process before you are able to request a State hearing.

If we need more time to make a decision for either a grievance or appeal, we will send you a letter telling you we need to take up to fourteen (14) more calendar days. That letter will also provide you with information as to why we need more time to complete your request.

State Hearing

You must complete the Gainwell appeal process before you are able to request a State hearing. AState hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Gainwell, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). During this meeting, you will explain why you think Gainwell Pharmacy Services did not make the right decisions and Gainwell will explain the reasons for making our decision. A decision will be made by the hearing officer based on rules, regulations, and information provided during the hearing.

You will be notified of your right to request a State hearing if we do not change our decision as a result of appeal to Gainwell. If you would like to request a State hearing, you or an authorized representative must request a hearing within ninety (90) calendar days of your denied appeal from Gainwell.

To request a hearing, you can sign and return the State hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at **1-866-635-3748** (**TTY/TDD 1-614-728-2985**), or submit your request via email to bsh@jfs.ohio.gov. If you want information on free legal services, you can call the Ohio State Legal Services Association at **1-800-589-5888** for the local number to your legal aid office.

State hearing decisions are usually issued no later than seventy (70) calendar days after the request is received. If it is determined that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three (3) business days after the request is received. Expedited decisions are for situations when the standard review time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

1.4 Change Recommendations

As a member of Gainwell Pharmacy Services, you have a membership right to make recommendations regarding rights and responsibilities surrounding medication coverage.

Recommendations can be emailed to Gainwell Pharmacy Services at:
OH_MCD_PBM@gainwelltechnologies.com
or call Member Services at **1-833-491-0344** (**TTY/TDD 614-728-2985**).

1.5 Pharmacy Access

Gainwell Pharmacy Services offers a member portal for you to log in and manage your pharmacy needs. To log in to your personal member portal, visit https://spbm.medicaid.ohio.gov and log in with your personal information that you have set up for your account.

To sign up for an account through the Gainwell Member Portal, you can follow the directions on the website at https://spbm.medicaid.ohio.gov or call Member Services toll free at **1-833-491-0344** (**TTY 1-833-655-2437**) to speak with a Gainwell Pharmacy Services agent to receive step-by-step assistance to sign up for access.

1.6 Emergency Outpatient Drug

In the event of an emergency situation, you will have the option to receive a 72-hour (3 day) supply of your medically necessary medication. If you have difficulties with this process, please contact Gainwell Pharmacy Services at **1-833-491-0344** (**TTY 1-833-655-2437**).

1.7 Non-Discrimination Statement

Gainwell Pharmacy Services follows State and Federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, gender, gender identity, sexual orientation, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, military status, veteran status, ancestry, the need for health services to receive any covered services or geographic location.

Gainwell has no moral or religious objections to services that we provide for Ohio Department of Medicaid members.

If you are in need of any additional services below, please contact Member Services toll free at **1-833-491-0344** (**TTY 1-833-655-2437**) to speak to a team member at no additional charge:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic
- Written information in alternative formats including, but not limited to, braille and large print

1.8 Provider Network Statement

Gainwell works with pharmacies to fill prescriptions close to your home for easy access to any of your medication needs. Many of the pharmacies offer services including prescription home delivery, medication management and assistance if you have limited English, hearing or sight difficulties, or a disability needing extra support. Specialty pharmacies also are available to provide medications with specific handling, storage, and distribution requirements to treat high risk, complex, or rare disease (s). If there are any changes to these pharmacies, we will be sure to let you know via the website, Gainwell Member Portal, or mailings as determined by your preferred communication request.

Gainwell does not cover prescription fills at pharmacies that are not signed up (Out of Network) to dispense medications for Ohio Medicaid members, which includes, but is not limited to, pharmacies that are far away from your home, except for emergency situations (if out of the State in an emergency or if an Ohio pharmacy cannot supply the medication).

1.9 Pharmacy Provider Network

You can obtain information on how to locate a pharmacy covered in your network by accessing the Pharmacy Provider Directory online at https://spbm.medicaid.ohio.gov or through logging in to your Gainwell Member Portal at https://spbm.medicaid.ohio.gov. You can request a paper copy of the Pharmacy Provider Directory by calling Member Services toll free at **1-833-491-0344 TTY 1-833-655-2437**).

Statement of Non-Discrimination

Buckeye Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Buckeye Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Buckeye Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - If you need these services, contact member services at 1-866-246-4358 TTY: 711

If you believe that Buckeye Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with: Buckeye Health Plan (Appeals Unit), 4349 Easton Way, Suite 120, Columbus, OH 43219, 1-833-236-9681 (TTY:1-800-750-0750), Fax 1-866-719-5404, Email BuckeyeGA@centene.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our grievance and appeals coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html. This notice is available on Buckeye Health Plan's website: www.buckeyehealthplan.com/non-discrimination-notice.html.

Language Assistance

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-246-4358 (TTY: 711).

Haitian Creole:

ATANSYON: Si w pale Kreyòl Ayisyen, genyen sèvis pou asistans lang gratis ki disponib pou ou. Rele 1-866- 246-4358 (TTY: 711)

Ukraninian:

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-246-4358 (телетайп: 711).

Nepali:

ध्यान दिनुहोस्: तपाइ□ले नेपाली बोल्नुह□न्छ भने तपाइ□को निम्त भाषा सहायता सेवाह□ निःशुल्क □पमा उपलब्ध छ । फोन गनुर्होस् 1-866-246-4358 [illegible]711)

Arabic:

لحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-668-642-8534 (رقم هاتف الصم

Somali:

LA SOCO: Haddii aad ku hadasho Ingiriisi, adeegyada taageerada luqada, oo bilaash ah, ayaad heli kartaa, Wac 1-866-246-4358 (TTY: 711).

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-246-4358 1-866-549-8289 (телетайп: 711).

Kiswahili:

NOTISI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha zinapatikana kwako bila malipo. Piga simu 1-866-246-4358 (TTY: 71U1).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-246-4358 (ATS : 711).

Kinyarwanda:

ICYITONDERWA: Niba uvuga Kinyarwanda, serivisi z'ubufasha bw'ururimi, z'ubuntu, zirahari kuri wowe. Hmagara 1-866-246-4358 (TTY: 711).

Uzbek:

DIQQAT: Agar oʻzbek tilini bilsangiz, til yordami xizmatlaridan bepul foydalanishingiz mumkin. Telefon qiling: 1-866-246-4358 (TTY: 711).

Pashtu:

پاملرنه: كه تاسو په پښتو ژبه خبرې كوئ نو د ژبې د مرستې وړيا خدمتونه ستاسو لپاره شتون لري. 1-866-246-4358 (TTY: 711) ته زنګ ووهئ.

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-246- 4358 (TTY: 711).

Tigrinya:

ምልክታ፦ Iቋንቋ ኢንግሊሽ እንድሕር ትዛረብ ኔንካ፣ ናይ ቋንቋ ሓገዝ ኣገልግሎታት ብናጻ ክቐርቡልካ እዮም። ብ 1-866- 246-4358 (TTY: 711) ደውል።

Dari:

توجه: اگر شما به زبان دری صحبت می کنید، خدمات کمک زبان، بطور رایگان برای شما موجود است. به شماره (711

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