Member Handbook

Ohio Medicaid Managed Care

844-912-0938 (TTY 711)

anthem.com/oh/medicaid

Find a doctor on your smartphone or tablet at **anthem.com/oh/medicaid**.

369610OHMENABS 03/24

If English is not your first language, we can translate for you. We can also give you info in other formats at no cost to you. That includes Braille, audio, large print, and providing American Sign Language interpreter services. Just give us a call at 844-912-0938 (TTY 711).

Spanish

Si su lengua materna no es el inglés, podemos brindarle una traducción. También podemos brindarle información en otros formatos, sin costo alguno para usted. Esto incluye Braille, audio, letra grande y servicios de intérprete del lenguaje americano de señas. Simplemente llámenos al 844-912-0938 (TTY 711).

Ukranian

Якщо англійська не є вашою рідною мовою, ми можемо надати вам послуги перекладу. Ми також можемо безкоштовно надати вам інформацію в інших форматах. Вони включають надання інформації шрифтом Брайля, в аудіоформаті, великим шрифом та надання послуг перекладача американської жестової мови.
Просто зателефонуйте нам за номером 844-912-0938 (TTY 711).

Haitian French Creole

Si angle pa lang natif natal ou, nou ka tradwi pou ou. Nou ka ba w enfòmasyon tou nan lòt fòma gratis. Sa enkli Bray, odyo, gwo lèt ak bay sèvis entèprèt Lang siy Ameriken. Jis rele nou nan 844-912-0938 (TTY 711).

Nepali

यदि अंग्रेजी तपाईंको पहिलो भाषा होइन भने हामी तपाईंको लागि अनुवाद गर्न सक्छौं। हामी तपाईंलाई निशुल्क अन्य ढाँचाहरूमा पनि जानकारी दिन सक्छौं। यसमा ब्रेल, अडियो, ठूलो प्रिन्ट र अमेरिकी सांकेतिक भाषाका दोभाषे सेवाहरू समावेश छन्। हामीलाई 844-912-0938 (TTY 711) मा कल गर्नुहोस्।

Arabic

إذا لم تكن اللغة اإلنجليزية هي لغتك األم، فيمكننا الترجمة لك. ويمكننا أي ًضا تزويدك بالمعلومات في تنسيقات أخرى مجانًا .يتضمن ذلك الكتابة بطريقة برايل والتسجيل الصوتي والمطبوعات المكتوبة بالحروف الكبيرة وتوفير خدمات الترجمة الفورية للغة اإلشارة األمريكية. فما عليك سوى االتصال بنا على الرقم (TTY 711) 844-912-0938.

Russian

Если английский не является вашим родным языком, мы можем организовать для вас услуги перевода. Кроме того, мы можем бесплатно предоставить вам информацию в

иных форматах. Это может быть шрифт Брайля, аудиоформат, крупный шрифт и услуги перевода на американский язык жестов. Просто позвоните нам по номеру 844-912-0938 (TTY 711).

Somali

Haddii Ingiriisigu aanau ahayn luqaddaada koowaad, waanu kuu turjumi karnaa adiga. Sidoo kale waxaanu ku siin karnaa macluumaadka ku qoran qaabab badan iyagoon adiga kharash kugu joogin. Taas waxaa ku jira Farta indhoolaha, maqal, daabcaada wayn, iyo bixinta adeegyada turjubaanada Luqadda Ishaarada Maraykanka. Naga soo wac 844-912-0938 (TTY 711).

French

Si l’anglais n’est pas votre langue principale, nous pouvons vous offrir un service de traduction. Nous pouvons également vous fournir des informations dans d’autres formats, sans aucun coût pour vous. Cela inclut le braille, l’audio, les gros caractères et la fourniture de services d’interprétation en langue des signes américaine. Appelez-nous simplement au 844-912-0938 (TTY 711).

Kinyarwanda

Niba Icyongereza atari ururimi rwawe rwa mbere, twabigusemurira. Ndetse ya aguha amakuru mu bundi buryo ku buntu. Ibyo bikubiyemo burayе, ibicapo binini, ndetse twagufasha serivisi y’ubusemuzi bw’ururimi rw’amarenga ya Amerika. Duhamagare gusa kuri 844-912-0938 (TTY 711).

Swahili

Ikiwa Kiingereza si lugha yako ya kwanza, tunaweza kutafsiri kwa ajili yako. Tunaweza pia kukupa habari katika miundo mingine bila malipo yoyote. Hii inatia ndani Maandishi ya Vipofu, Sauti, Chapa Kubwa na kukupa huduma za mtafsiri wa Lugha ya Ishara/Alama ya Amerika. Tupigie simu kwa nambari 844-912-0938 (TTY 711).

Uzbek

Агар инглиз тили она тилингиз бўлмаса, сиз учун таржима хизматини таклиф қиламиз. Маълумотларни бошқа форматларда сизга харажатсиз тақдим этишимиз мумкин. Бунга Брайл алифбоси, аудио, катта босма ва Америка имо-ишора тиллари бўйича таржимонлик хизматларини тақдим этиш киради.
844-912-0938 (TTY 711) рақамига телефон қилинг.

Pashto

که انګلیسي ستاسو لومړۍ ژبه نه وي، موږ کولی شو ستاسو لپاره ژباړه وکړو. موږ کولی شو تاسو ته پرته له کوم لګښت څخه په نورو فارمیټونو کې معلومات درکړو. پدې کې بریل، آډیو، لوی چاپ، او د امریکا د ګونګیانو ژبې ژباړونکي خدمتونه شامل دي. یوازې موږ ته په 844-912-0938 (TTY 711) تلیفون وکړئ.

Turkish

İngilizce ana diliniz değilse, sizin için çevirebiliriz. Hiç bir ödeme yapmadan size diğer formatlarda da bilgi sağlayabiliriz. Buna, Braille alfabesi, ses, büyük baskı ve Amerikan İşaret Dili tercümanlık hizmetleri de dahildir. Bizi 844-912-0938 (TTY 711) numaralı telefondan aramanız yeterli.

Dari

اگر انگلیسی زبان مادری شما نیست، ما می توانیم برای شما ترجمه کنیم. ما همچنین می توانیم بدون مصرف معلومات را در نمونه های دیگر به شما ارائه دهیم. این شامل خط بریل، صدا، چاپ بزرگ و ارائه خدمات ترجمان زبان اشاره آمریکایی است. فقط با شماره (TTY 711) 844-912-0938 به ما زنگ بزنید.

Vietnamese

Nếu Tiếng Anh không phải là ngôn ngữ mẹ đẻ của quý vị, chúng tôi có thể biên dịch cho quý vị. Chúng tôi cũng có thể cung cấp cho quý vị thông tin ở các định dạng khác miễn phí. Các định dạng đó bao gồm chữ nổi Braille, âm thanh, bản in lớn và cung cấp dịch vụ thông dịch viên Ngôn ngữ Ký hiệu Hoa Kỳ. Chỉ cần gọi cho chúng tôi theo số 844-912-0938 (TTY 711).

If you have a problem reading or understanding this information or any other Anthem information, please contact our Member Services toll-free at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help at no cost to you. We can explain this information, in English or in your primary language.

You also can use our member website to communicate with us, stay updated and find additional information on benefits, claims, and resources. Please visit **anthem.com/oh/medicaid** to find out more.

Welcome to Anthem Blue Cross and Blue Shield. You are now a member of a healthcare plan, also known as a managed care organization (MCO). Anthem provides healthcare services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, children, older adults, and individuals with disabilities.

STATEMENT OF NON-DISCRIMINATION

Anthem does not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, education status, veteran status, ancestry, disability, genetic information, health status, or the need for health services, and complies with all applicable State and Federal civil rights laws.

Upon request, Anthem will provide supportive devices, tools, help, and other resources, also known as 'auxiliary aids and services', at no cost to its current and potential members with disabilities. This includes but is not limited to qualified oral and written translation help on your language, including the American Sign Language, accessible formats such as large print, Braille materials and displays, audio, assistive listening device, and other tools and formats.

If you need any of these services, please contact our Member Services toll-free at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

If you believe that Anthem has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, ethnicity, religion, gender, gender identity, sexual

orientation, military status, genetic information, ancestry, health status, or need for health services, you can file a complaint with Anthem by:

- Calling Anthem's Member Services toll-free at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time; or
- Logging into the secure member portal, at https://member.anthem.com/public/login, or on the mobile app and finding Grievances under Support
  Printing the form found at **anthem.com/oh/medicaid/member-resources** and emailing it to **ohioga@anthem.com** or faxing it to us at 866-587-3316.

If you need help filing a grievance, Anthem is available to help you, free of charge.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by mail or phone at:

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

About this member handbook

This handbook will help you understand your healthcare plan. The other side of this handbook is in Spanish. If you have questions, need help understanding or reading something in here, or want this in a different language, call us. We'll let you know when it can be available.

You can also receive this member handbook in:

- A large-print version.
- An audio version.
- A braille version.

When there are benefit changes or other changes that impact your care and services, we will let you know in one of these ways:

- We will send you a letter.
- We will send you a notice to keep with your member handbook.
- We will update our member website at **anthem.com/oh/medicaid**.

It is important to remember that you must receive services covered by Anthem from facilities and providers in the Anthem network. Providers in the Anthem network agree to work with your health plan to give you needed care.
The only time you can use providers that are not in the Anthem network is for:

- Emergency services,
- Federally qualified health centers (FQHC)/rural health clinics (RHC),
- Certified nurse midwives or certified nurse practitioners if Anthem does not contract with such providers and such providers are present in the service area,
- Qualified family planning providers,

- An out-of-network provider that Anthem has approved you to see.

Benefits beyond what you'd expect
With Anthem, you'll receive your regular Medicaid benefits, plus extras designed to make a difference in your life:

- Need a doctor's help late at night? Use LiveHealth Online to video chat with a doctor anytime. They can help with minor illnesses like colds, allergies, flu, or infections.
- Baby essentials
- Mail order diapers
- Organic baby food coupons
- Post discharge meals
- [One-on-one tutoring]
- Laptop computer
- Childcare assistance for educational and employment pursuits
- Industry certification assistance
- Substance use disorder recovery support
- Over-the-counter supplies
- Transportation essentials
- Online well-being program
- Enhanced dental
- Enhanced vision
- Housing and Employment supports to help with needs

We're just a call or a click away.
When you have questions or need help, our team is ready and willing to assist. Our website has many of the answers you need. Visit **anthem.com/oh/medicaid** to:

- Learn more about your benefits.
- Choose or change your PCP.
- Use our **Find a doctor** tool to search for a doctor by name, type, or location.
- And a lot more.

You can also call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time. If you have health questions and want to talk with a registered nurse, call 24/7 NurseLine at **844-430-0341 (TTY 711)**. Our nurses are available anytime, day or night.

Sincerely,

Anthem Blue Cross and Blue Shield

To update your address or phone number, please call Ohio Department of Medicaid at:
800-324-8680 (TTY 711).

Frequently asked questions

1. How do I change my primary care provider?
   See the **How to change your primary care provider** section.

2. Where can I find a list of behavioral health providers?
   See the **Where to find a list of Anthem network providers** section or go to **anthem.com/oh/medicaid**.

3. As an adult member, does Anthem cover my care?
   See the **Wellness care for adults** section.

4. What if I don't have transportation to my doctor appointment?
   See the **Transportation** section.

5. I don't have a phone. How can I communicate with Anthem or my doctors?
   See the **Extra Anthem benefits** section.

6. How do I find out if my medication has been approved or requires authorization?
   See the **Medication** section.

7. How can I receive another copy of my ID card?
   See the **Go online** section; **Download the Anthem Medicaid app** section or the **Your Anthem identification card** section.

ANTHEM BLUE CROSS AND BLUE SHIELD MEMBER HANDBOOK

8940 Lyra Drive Ste 300
Columbus, OH 43240
844-912-0938
(TTY 711)
anthem.com/oh/medicaid

Welcome to Anthem Blue Cross and Blue Shield. You'll receive most of your Medicaid benefits through Anthem. This member handbook will tell you how to get the most from your benefits.

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WELCOME TO ANTHEM BLUE CROSS AND BLUE SHIELD

Your new health plan

Anthem Blue Cross and Blue Shield provides your Medicaid benefits. We're the health plan that will help you make the most of them. Working with you and your doctors, we will help you feel your best and stay healthy.

We offer healthcare coverage to individuals living in Ohio.

The state requires us to give you the information below.

Please note that all monthly payments from Medicaid to Anthem may be recovered by Medicaid as a claim against your estate if we cover services included under Ohio's plan for estate recovery* and you are one of the following:

- Age 55 or older.
- An inpatient of a medical facility.

Medicaid can't recover payments from estates of deceased Medicaid members if there is a:

- Surviving spouse.
- Child under 21 years old.
- Child of any age with a disability or blindness.

How to find help

Call Member Services

We're here to help you. Call us at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time if you:

- Have any questions about our health plan or your benefits.
- Need help receiving care or finding a plan provider.
- Need an interpreter to help you communicate with your doctor in your native language or are deaf or hard of hearing.
- Want to suggest how we can make your health plan better.
- Want to participate in a committee to help improve healthcare services and community education.

You also can send a secure message or live chat with a Member Services representative at **anthem.com/oh/medicaid**.

Call 24/7 NurseLine

Call 24/7 NurseLine at **844-430-0341 (TTY 711)** anytime, day or night. Our nurses can help if you have health-related questions or need advice on:

- What to do to take care of yourself before you see the doctor.
- How soon you need to receive care for an illness.
- When to go to the emergency room or urgent care center.

- How you can receive the care you need.

Go online

Visit our website at **anthem.com/oh/medicaid**. You can:

- Choose or find a primary care provider (PCP) in the Anthem network.
- Change your PCP.
- View and share your ID card.
- Live chat or send a secure message to Member Services.
- Check for authorized services and claims
- Review OhioRISE claims
- Update your address or phone number. Please also call the Ohio Department of Medicaid at **800-324-8680 (TTY 711)**.
- Download or request a member handbook or provider directory.
- Learn about community programs and services.
- Ask questions or make comments to help improve Anthem.
- Learn about your rights and responsibilities as a member.
- Report waste, fraud, and abuse.
- Read what we are doing to keep your private information safe and receive a copy of the Anthem Notice of Privacy Practices. This Notice describes how your medical information may be used and shared, and how you can access it.
- Learn about pharmaceutical management procedures.
- Learn how to access transportation services

Download the Sydney Health mobile app

Now you can access your Anthem member identification (ID) card and find doctors in our network from your smartphone or tablet. Just download the Sydney Health mobile app. With our free mobile app, you can show or email your member ID card to your doctor, pharmacy, or hospital. You can also use our interactive symptom checker and live chat with Member Services – right from your phone. You'll need your ID number, located on the front of your Anthem member ID card, to set up your account.

To download the Sydney Health mobile app, go to the App Store®, Google Play™, or visit our website at **anthem.com/oh/medicaid**.

Important phone numbers

Name	Description	Phone number
24/7 NurseLine	Receive medical advice or talk with a registered nurse about any nonemergency health-related questions or concerns.	**844-430-0341 (TTY 711)**
Anthem Member Services	Receive a member handbook, update your member identification card, find a new provider, schedule an appointment, and much more.	**844-912-0938 (TTY 711)**
Behavioral healthcare	Find information about behavioral healthcare.	**844-912-2425 (TTY 711)**
Case Management	Call to be connected with your case manager.	**844-441-1505 (TTY 711)**
Disease Management programs	Speak with a Disease Management case manager if you have a chronic condition.	**888-830-4300 (TTY 711)**
Emergencies	**Call or go to the nearest hospital emergency room.**	**911**
DentaQuest	Find out information about your dental benefits	**888-291-3762 (TTY 800-466-7566)**
EyeMed	Find out information about your vision benefits.	**877-658-1801 (TTY 711)**
Transportation Services	Arrange for transportation to medically needed appointments and treatments.	Toll free at **800-282-9720 (TTY 711)**
Ohio Medicaid	Find out more about Ohio Medicaid program eligibility and other information.	**800-324-8680 (TTY 800-292-3572)**
Utilization Management	Questions about an approval or a denial you received	**844-912-0938 (TTY 711)**
OhioRISE	For more information on OhioRISE services, please contact Aetna Better Health of Ohio Member Services	**833-711-0773** (TTY 711)
Ohio Single Pharmacy Benefit Manager (SPBM) via GainWell	Find out more about your pharmacy benefits	**833-491-0344 (TTY 833-655-2437)**

Identification (ID) Cards

You should have received an Anthem membership ID card. Each member of your family who has joined Anthem will receive their own card. Each card is good for as long as the person is a member of Anthem.

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

Call Anthem Member Services as soon as possible at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time 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.

Always keep your ID card(s) with you

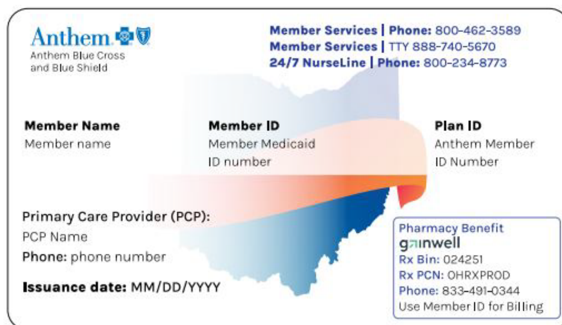
You will need your ID card each time you get medical services. This means that you need your Anthem ID card when you:

- 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.
- Schedule transportation.

Ohio Medicaid ID card

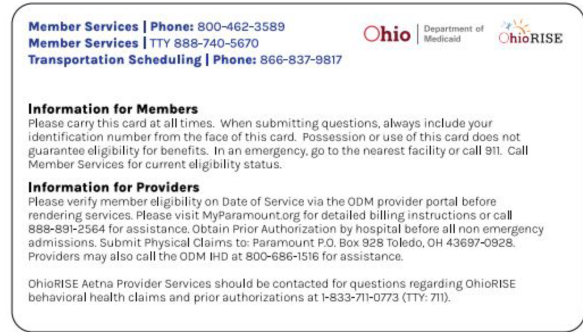
This card identifies you as an Anthem member.

Front | **back**



This card identifies you as an Anthem member who is also enrolled in OhioRISE.

Front | **back**



Your Anthem ID card shows:

- The name and phone number of your PCP.
- Your Medicaid number.
- The issuance date
- Important phone numbers.

If your Anthem ID card is lost or stolen, call us right away at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time. We'll send you a new one.

For members who don't speak English or prefer to speak in a language other than English:

- We can help in many different languages and dialects.
- We'll provide an interpreter to help you talk to your doctors during your appointments. Please call Member Services at least 24 hours before your appointment.
- All materials can be requested in a language of your choice, request materials in a language other than English by calling Member Services.

For members who are deaf or hard of hearing:

- Call **711** to reach Member Services.
- If you need a sign language interpreter for a doctor visit, please call us at least five business days before your appointment. We'll set up and pay for the service.

New member information

If you have healthcare services already approved or scheduled, it is important that you call Member Services <u>immediately</u>. In certain situations, and for a specified time period after you enroll, you may be allowed to receive care from a provider that is not an Anthem network provider. **<u>You must call Anthem before you receive the care.</u>** 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 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

Your providers

Choosing a primary care provider (PCP)

You must choose a primary care provider (PCP) from the Anthem provider directory. Your PCP is an individual provider or provider group practice trained in obstetrics/gynecology (OB/GYN), family medicine (general practice), internal medicine, or pediatrics.

Your PCP will work with you to direct your healthcare. Your PCP will do your checkups, shots, and treat you for most of your routine healthcare needs. If needed, your PCP will send you to providers, 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 Anthem ID card.

All our members must have a primary care provider (PCP) in the Anthem plan. Your PCP is your regular doctor who you'll see for all your basic healthcare needs — such as yearly checkups, minor illnesses, or referrals to specialists. They will:

- Learn about you and your health history.
- Provide all your basic health services and send you to other doctors or hospitals when you need special care.
- Help you receive the right care.

When you became an Anthem member, you should have picked a PCP. If you didn't choose one, we assigned one to you. We picked one close to your home. The name and phone number of your PCP is on your Anthem ID card. You may also choose a primary care site (PCS), such as a Federally Qualified Health Center (FQHC), and receive medical care from any doctor in the PCS. It is important to schedule an appointment with your PCP within the first 90 days of enrollment with Anthem. You need to discuss your health history and medications with him or her as soon as possible.

If you are already seeing a PCP, you can look in the provider directory on our website at **anthem.com/oh/medicaid** or printed provider directory, if you have requested one, to see if that provider is in our network. You also can call Anthem Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time. If your PCP is in our network, you can tell

us you want to keep him or her by calling Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

If you are not happy with the PCP we assigned, you can pick another provider once per month. Just look in the provider directory that came with your new member package or log in to your online account at **anthem.com/oh/medicaid**. Our search tool lets you search for providers by name, location, and specialty.

Need help? Call Member Services and our Concierge team would be happy to help find providers and schedule appointments at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time. No matter how you make the change — online or on the phone — we'll send you a new member ID card.

Your PCP can be any of the following, as long as he or she is in the Anthem network:

- Family or general practitioner
- Internist
- Pediatrician
- Specialist (for those with a disability, chronic, or complex conditions)
- Physician assistant
- Certified nurse practitioner
- Obstetricians/gynecologists (during pregnancy)

You can also pick a Federally Qualified Health Center (FQHC) as your PCP if you would like.

You and your children don't have to have the same PCP. If you are pregnant, your newborn will be assigned to the same PCP as the other covered children in the family.

You may be able to have a specialist or a state-operated clinic as your PCP if you have a:

- Disability.
- Chronic condition.
- Complex condition.

Your specialist must agree to take on PCP responsibilities for your care. Members with disabilities have additional time to select a PCP. If you don't select a PCP, we will automatically assign one to you. You can ask us to change your PCP at any time.

Where to find a list of Anthem network providers

The Provider Directory lists all our network providers you can use to receive services. You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card. You can also visit our website at **anthem.com/oh/medicaid** to view up-to-date provider network information or call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help.

The provider directory lists primary care providers (PCPs), behavioral health providers, specialists, optometrists, chiropractors, drug stores, and hospitals that participate with Anthem. The directory shows if the provider is accepting new patients and if they are board-certified.

The directory also lists:

- Provider Name and practice or group affiliation
- Office addresses
- Office phone numbers
- Office hours
- Languages spoken at the office and cultural competence training status, if available
- Professional qualifications
  - Provider Specialty
  - Medical school attended and Residency completion
  - Provider's office/facility accessibility and accommodations
  - Telehealth availability
  - Provider's website, as appropriate

If you did not receive a provider directory, please contact Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help. We'll send you a new directory. You can also search for a provider online by going to **anthem.com/oh/medicaid** and selecting **Find a Doctor**.

If you need a provider directory in different format, or language other than English, or you have other special needs request, please call Anthem.

Seeing an out-of-plan provider

There may be times when you will need to see a provider who is not part of the Anthem network. If you were ill or injured before joining Anthem and were seeing a PCP who is not in our network, please let us know about the care you were receiving. In some cases, you may be able to keep seeing this PCP while you pick a new one in our network. Call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time to find out more. Anthem will work with you and your PCP to provide a smooth transition to your new PCP.

If you require medically needed care that is not available from a plan provider and your PCP requests the services, Anthem will provide those services at no cost to you for as long as the service you need is required and not available from a plan provider.

To see an out-of-plan provider, you or your doctor will need to ask for approval from us first.

If your PCP's office moves, closes, or leaves the Anthem plan

Your PCP's office may move, close, or leave our plan. If this happens, we will:

- Call or send you a letter 45 days prior to the date the provider will move, close, or leave our plan. If we find out less than 45 days prior to the provider's termination date, we will call or send you a letter within one working day of finding out. In some cases, you may continue seeing this PCP while you pick a new one.
- Work with you and your PCP to provide a smooth transition to your new PCP.
- Help you pick a new PCP if you call Member Services for help.

- Send you a new ID card within five business days after you pick a new PCP.

Changing your PCP

If you want to change your PCP, you must first call Member Services to ask for the change. You can change your PCP on your ID card once a month, if you want.

If you need to change your PCP, you may pick another PCP from the network. To change your PCP:

1. Use our provider search tool at **anthem.com/oh/medicaid**.
2. Log in to your online account at **anthem.com/oh/medicaid** or call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

When you ask to change your PCP:

- We can make the change the same day you ask for it.
- The change will be effective the next day.
- You'll receive a new ID card in the mail within five business days after your PCP has been changed.
- You do not need to wait for your new ID card to see your new PCP

Anthem will send you a letter with a new ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP. For the names of the PCPs in Anthem, you may look in your provider directory if you requested a printed copy, on our website at **anthem.com/oh/medicaid**, or you can call the Anthem Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help.

If your PCP asks for you to be changed to another PCP

Your PCP may ask for you to be changed to another one. They may do this if:

- Your PCP does not have the right experience to treat you.
- The assignment to your PCP was made in error (like an adult assigned to a child's PCP).
- You fail to keep your appointments without calling the PCP to let them know or schedule a new appointment.
- You do not follow their medical advice over and over again.
- Your PCP agrees a change is best for you and your medical needs.

If your PCP asks you to change to another PCP for any of these reasons, please contact Member Services for help finding a new PCP or check the provider directory. You may also use the **Find a Doctor** tool online at **anthem.com/oh/medicaid**.

If you want to see a provider who is not your PCP

If you want to see a provider who isn't your PCP, talk to your PCP first. They may give you a referral to see another provider.

Please read the section about **Specialists** to learn more about referrals. Also, read the section **Services That Do Not Need a Referral** for more details.

Second opinions

Anthem members have the right to ask for a second opinion about any treatment or diagnosis at no cost. You can seek a second opinion from a network provider or a non-network provider if a network provider is not available. It means you can discuss the issue with a different network provider. Ask your PCP to submit a request for you to have a second opinion. If you cannot find a network provider, we will help you to find one outside the network, at no cost to you. Call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help.

Picking an OB/GYN

Members can see a network OB/GYN. These services are no additional cost to members and include:

- Wellness visits.
- Prenatal care.
- Family planning.

You do not need a referral to see any qualified family planning provider, even if this provider is not part of the Anthem network.

Your PCP may be able to treat you for OB/GYN care. If not, you will need to see a network OB/GYN. To find an OB/GYN from the list of network providers:

- Look in the Anthem provider directory that came with your new member packet.
- Go to our online provider directory at **anthem.com/oh/medicaid**.
- Call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

While you are pregnant, your OB/GYN can be your PCP. The nurses on 24/7 NurseLine can help you decide if you should see your PCP or an OB/GYN.

If you are pregnant when you enroll in Anthem and your current provider is not part of the Anthem plan, you may be able to continue receiving OB/GYN care from your current provider. This is called continuity of care. Call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time for more information.

Going to a specialist

Your PCP can take care of most of your healthcare needs, but sometimes you may also need care from other kinds of providers. There are many different kinds of providers in our plan who give other medically needed care. These providers are called specialists because they have training in special areas of medicine.

Examples of specialists are:

- Allergists (allergy doctors).
- Dermatologists (skin doctors).
- Cardiologists (heart doctors).

If you need to see a specialist, your PCP will give you a referral. The referral form tells you and the specialist what kind of healthcare you need. Be sure to take the referral form with you when you go to the specialist.

In a few cases, a referral isn't needed. Read the section in this handbook, **Services That Do Not Need a Referral**, for more details.

Sometimes, a specialist can serve as your PCP. This may happen if you have a special healthcare need that requires specialist care. If you believe you have special healthcare needs, you can:

- Talk to your PCP.
- Call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time for more information.

If you're receiving care from a specialist who is not part of our plan when you join Anthem, please let us know. In some cases, you may continue seeing them until you can switch to an Anthem plan specialist. Call Member Services to find out more.

If you are currently receiving care from a specialist whose office is moving, closing, or who will no longer participate in our plan, we will:

- Call or send you a letter within 15 calendar days of receiving the provider termination notice. In some cases, you may continue seeing this specialist for care while you pick a new one. Call Member Services to find out more about this.
- Work with you and your PCP to ensure a smooth transition to your new specialist.
- Help you pick a new specialist if you need help.

RECEIVING HEALTHCARE

How to make an appointment with your PCP

It is important to visit your PCP for regular checkups, called wellness visits, and for care when you are ill. Call your PCP's office whenever you need care. The phone number is on your Anthem ID card.
If you were assigned a new PCP when you enrolled in Anthem, it is important to schedule a wellness visit within 90 calendar days. If your PCP did not change when you enrolled, call them to see if it is time for a checkup. If so, set up a visit with your PCP as soon as you can.

Wellness visits can help you stay healthy and let your PCP take better care of you when you are sick. When you are not feeling well, call your PCP's office. Let them know your symptoms, and they will tell you how soon you need to be seen. If you need help making an appointment, call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

Type of visit	Description	Minimum standard
Emergency service	Services needed to evaluate, treat, or stabilize an emergency medical condition.	24 hours, 7 days/week

Type of visit	Description	Minimum standard
Urgent care (includes medical, behavioral health, and dental services)	Care provided for a nonemergent illness or injury with acute symptoms that require immediate care; examples include but are not limited to sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain, and severe, non-resolving headache. Acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request
Behavioral health nonlife threatening emergency	A nonlife threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral health routine care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Primary care appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 6 weeks
Non-urgent sick primary care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days
Prenatal care — first or second trimester	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	First appointment within 7 calendar days; follow-up appointments no more than 14 calendar days after request
Prenatal care — third trimester or high-risk pregnancy	Care provided to a member while the member is pregnant to help keep member and future baby healthy, such as checkups and prenatal testing.	Within 3 calendar days
Specialty care appointment	Care provided for a non-emergent/non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks

Type of visit	Description	Minimum standard
Dental appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

After-hours callbacks

We want you to be able to receive care at any time. When your PCP's office is closed, an answering service will take your call. Your PCP should call you back within 30 minutes. Talk to your PCP and set up an appointment.

What to bring to an appointment

When you visit your provider, be sure you have:

- Your Anthem ID card.
- Any medicines you are taking.
- Any questions you may want to ask.

If the appointment is for your child, be sure you bring your child's:

- Identification (ID) cards.
- Shot records.
- Any medicine they are taking.

How to cancel an appointment

If you make an appointment and then cannot go, it is important to:

- Cancel the appointment at least 24 hours in advance. You can call the doctor's office or call Member Services and ask us to cancel for you. This will let someone else make an appointment at that time.
- Make a new appointment when you call to cancel.

Your PCP may ask us to switch you to a new PCP if you frequently miss appointments without cancelling.

Telehealth

Telehealth is the direct delivery of healthcare using 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 to use telehealth and telehealth removes the stress of needing transportation services.

You 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 for prescribing medication(s).

Check with your providers to see if they offer telehealth.

Transportation

If you must travel 30 miles or more from your home to receive covered healthcare services, Anthem will provide transportation. Please call Anthem transportation services toll-free at 1**-800-282-9720 (TTY 711)** , Monday through Friday, 8 a.m. to 7 p.m. Eastern time.

In addition to the transportation assistance that Anthem provides, you can get 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.

How to schedule a ride:

- Call Transportation Services toll-free at 1**-800-282-9720 (TTY 711)** 48 hours, or two business days prior to your scheduled routine appointment.
- Reservations can be made up to 30 days in advance. Reservations for repeat appointments such as dialysis, chemotherapy, or radiation can be scheduled for a period of 90 days at a time.
- For an urgent/same day appointment or facility discharge, members may call the Anthem Transportation Services line toll-free reservation line at 1**-800-282-9720 (TTY 711)**, 24 hours a day, seven days a week.

You will need to provide the following information when calling transportation services:

- Your plan member ID number (located on your member ID card)
- Your full name
- Your date of birth
- Your current address
- Your phone number
- Details for pick-up address and drop-off of appointment address
- Specific appointment date and time

Who can call to schedule a ride?

- Members at least 18 years of age
- The minor member's parent or legal guardian
- An authorized representative
- Members who are emancipated minors
- The member's caregiver, a case manager, or other medical providers and/or facilities (such as hospitals)

How will you get to your appointment?

Types of vehicles that may be used for transportation include:

- Car
- Taxi
- Ride-sharing vehicle
- Wheelchair lift-equipped van

The type of vehicle used will be based on your mobility and physical needs. You can specify special needs or special instructions during the call intake. You will need to be ready 15 minutes before their scheduled pickup time.

Ambulatory members can request the rideshare option or a bus pass. If you have someone who can drive you to and/or from your appointment, you can request mileage reimbursement when scheduling your ride.

How will you get home from your appointment?

If you call for a ride after your appointment (will call), the driver should pick you up within 30 minutes.

How can you cancel or reschedule a ride?

Contact transportation services to cancel or reschedule a transport, please call transportation services at **800-282-9720 (TTY 711)**. You also can cancel a transport using the Access2Care mobile app.

If you have an emergency and need transportation, call 911 for an ambulance.

Access for members with special needs

Anthem plan providers and hospitals should help members with disabilities receive the care they need. If you use a wheelchair, walker, or other aid and need help entering an office:

- Make sure your provider's office knows this before you go to your appointment. This will help them be ready for your visit.
- Call Member Services if you want help talking to your doctor about your special needs.

WHAT DOES MEDICALLY NECESSARY MEAN?

Your PCP will help you receive medically necessary services. **Medically necessary health services** are:

- Necessary to diagnose, treat or prevent illness, injury, or disease.
- Necessary to regain or improve the ability to perform the activities and tasks of daily living.
- Consistent with the symptoms or diagnosis of the illness or injury being treated.
- Consistent with generally accepted professional medical standards, including:
  - Guidelines and standards that are endorsed by professional healthcare or government agencies.
- Not experimental (not new or untried).

- Safe and effective for the member (Medicaid will only cover items and services that are needed for the diagnosis or treatment of an illness or an injury, or to improve the working of a malformed body part). This does not include cosmetic procedures.
- Not mainly for the convenience of the member, the member's caregiver, or the provider.
- Not for cosmetic purposes.

As an Anthem member, you and your doctor together will decide what treatment plan is best for you. If the services you receive are not helping you then they might be stopped or changed to best meet your needs. Services are also stopped when they are not medically necessary.

HEALTHCARE BENEFITS AND PREMIUMS

Anthem benefits

Below is a summary of the healthcare services and benefits Anthem offers. Your PCP will either give you the care you need or refer you to another provider.

For some benefits, you must be a certain age or have a certain kind of health problem. In some cases, your PCP may need to receive prior approval from Anthem before you can receive a benefit. Your PCP will work with us to receive approval. If we do not approve a service, your PCP may provide you with another service.

There are no copays or deductibles required for any covered services.

If you have a question or are not sure if Anthem offers a certain benefit, call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

Prior authorization (preapproval)

Some Anthem services and benefits need prior authorization (preapproval). This means your doctor must ask Anthem to approve the services or benefits before the service is provided. Emergency services, post-stabilization services, and urgent care do not need prior approval.

Anthem has a Utilization Review team that looks at service requests. The team will decide:

- If the service is needed and if it is covered by Anthem.

Within 10 calendar days after receiving the request and clinical information from your doctor. Your doctor can ask for an expedited review if a delay could cause serious harm to your health. We will notify your doctor of our decision within 48 hours of receiving the urgent request.

If we say we will not pay for the care, or the approved services are less than the amount or type requested, you or your doctor can ask for an appeal. To learn more about the appeal process, see the **Grievances and Medical Appeals** section. If you appeal, we will notify you of our decision within 15 days. If you have a question or aren't sure if we offer a certain benefit, you can call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time, for help. For a list of the services we cover, go to the **Anthem covered services** section.

HOW WE MAKE DECISIONS ABOUT YOUR CARE

Sometimes we need to review care and services to make sure they are medically necessary. This is called Utilization Management (UM). Our UM process follows National Committee for Quality Assurance (NCQA) standards. All UM decisions are based on members' medical needs and current benefits.

We do not encourage providers or our staff to make decisions that result in underuse of services. In addition, we do not create barriers to receiving healthcare. Providers are not rewarded financially or any other ways for limiting or denying care. Anthem providers use clinical practice guidelines to determine necessary treatments and services.

Listed below are some of the benefits we cover. If a service is not listed, please check with your provider or contact us.

Some services are limited by the number of provider visits or by the number of supplies and equipment items. We have a process to review requests from you or your provider for extra visits or extra supplies. We also have a process to review requests for non-covered services when they are medically necessary. Remember to call us before you receive medical services or ask your PCP to help you.

You might need a referral from your PCP or approval from us before you can receive some services. If you do not have a required referral form or preapproval, then some services might not get covered and paid. When you ask or your provider asks for certain care that needs preapproval, our Utilization Review team decides if the service is medically necessary and covered by Anthem.

You also can contact us if you need more information, have questions, or want to request a copy of UM clinical guidelines and criteria. Please call us at **844-396-2329 (TTY 711)** to speak with our Utilization Management (UM) representative, Monday through Friday from 7 a.m. to 8 p.m. Eastern time. Oral interpretation regarding all UM matters, including benefits and access to medical services, is available to all members free of charge. If you have difficulty understanding English and need language assistance to discuss UM issues, please contact our Member Services toll-free at **844-912-0938 (TTY 711),** Monday through Friday from 7 a.m. to 8 p.m. Eastern time, for help at no cost to you. Our bilingual staff or an interpreter can explain this information in your primary language.

Some of the services listed below may need preapproval; please ask your provider for more information or contact us Monday through Friday from 7 a.m. to 8 p.m. Eastern time. To speak to a UM representative, please call **844-396-2329 (TTY 711)**.

*** Anthem does not cover testing, medication, or treatment that is experimental,** such as a new treatment that is being tested or has not been shown to work.

SERVICES COVERED BY ANTHEM

As an Anthem member, you will receive all medically necessary Medicaid-covered services at no cost to you.

- Acupuncture — to treat certain conditions.
- Allergy services
- Ambulance and wheelchair van transportation
- Behavioral Health Services (including mental health and substance use disorder treatment)
- Certified nurse midwife services
- Certified nurse practitioner services
- Chemotherapy services
- Chiropractic (back) services
- Dental services
- Developmental therapy services for children aged birth to six years
- Diagnostic services (X-ray, lab)
- Durable Medical Equipment (breast pump, breast milk storage bags, walking aid, blood pressure)
- Emergency services
- Family planning services and supplies
- Free-standing birth center services at a free-standing birth center. Call Member Services to find a qualified center near you.
- Federally Qualified Health Center (FQHC) or Rural Health Clinic services (RHC)
- Gynecological Services (OBGYN)
- Home health services
- Hospice care
- Inpatient hospital services
- Medical nutrition therapy (MNT) services
- Nursing facility services. Anthem will cover the stay for members unless the Ohio Department of Medicaid determines that the member will return to fee-for-service Medicaid. If the member needs nursing services, they should call Member Services for information on available providers.
- Maternity care — prenatal and postpartum including at-risk pregnancy services
- Outpatient hospital services
- Pharmacist services
- Physician services
- Physical and occupational therapy
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source
- Podiatry (foot) services
- Prescription drugs, including certain prescribed over-the-counter drugs
- Preventative mammogram breast cancer and cervical cancer screenings
- Primary care provider services
- Renal dialysis (kidney disease) services
- Respite services (for members under 21 years of age with LTC or BH needs)
- Screening and counseling for obesity
- Services for children with medical handicaps (Title V)
- Shots (immunizations)
- Specialist services including:
    - Allergy
    - Behavioral Health

    - Cardiology
    - Dental
    - Outpatient dialysis
    - ENT/Otolaryngology
    - Gastroenterology
    - General surgery
    - Gynecology
    - Hospital
    - Nephrology
    - Neurology
    - Oncology
    - Oral surgery
    - Orthopedics
    - Pediatrics
    - Pediatric dentistry
    - Pediatric behavioral health
    - Podiatry
    - Psychiatry
    - Radiology
    - SUD-outpatient services
    - SUD-residential
    - Surgical services
    - Outpatient
    - Urology
- Speech and hearing services, including hearing aids
- Telehealth services
    - Telehealth services are covered for many illnesses and injuries, common health conditions, follow-up appointments, and screenings as well as for prescribing medications. Check with your provider to see if they offer any of the following covered services:
        - Medical and Behavioral Health Services
        - Long Term Services and Supports
        - Occupational/Physical Therapy
        - Speech-Language Pathology
        - Audiology
        - Dental
        - Specialized Recovery Services (SRS) Program
- Tobacco cessation services, including tobacco cessation counseling and FDA-approved medications for tobacco cessation. Call **800-QUIT-NOW (800-784-8669)** and speak with an intake specialist to discuss assistance to help you quit tobacco.
- Vision (optical) services, including eyeglasses
- Well-child (Healthchek) exams for children under the age of 21
- Yearly well-adult exams

COVID TESTING AND VACCINATIONS

Anthem will cover all Medicaid-covered COVID-19 testing, treatment, and vaccinations at no cost to you.

COVID testing locations can be found online at: **https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers**

The Ohio Department of Health (ODH) has developed a search tool for Ohioans to use to find a vaccine provider. The directory is searchable by county and ZIP code and displays providers currently receiving shipments of COVID vaccines. You can get information and vaccination locations at https://vaccine.coronavirus.ohio.gov/ or by calling the Ohio Department of Health toll free at **833-427-5634**.

Anthem can assist you in finding a testing or vaccination location in your community. They also can help with scheduling and transportation to the appointment. Contact your plan at **anthem.com/oh/medicaid** or by phone at: Member Services toll-free at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

The Ohio Department of Health provides regular vaccination updates on the eligibility phases at: **https:// coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program**.

COVERED SERVICE	ADDITIONAL INFORMATION
ALLERGY SERVICES	Covered services include: • Treatment — Immunotherapy (commonly called allergy shots) is a useful treatment for patients with allergies. It is based on the belief that people who receive injections of a specific allergen will no longer be sensitive to it. • Testing — Allergy tests are used to determine what a person is allergic to. There are many methods of allergy testing. Common types include: – Skin tests – Elimination-type tests
APPLIED BEHAVIORAL ANALYSIS (ABA)	Applied Behavioral Analysis (ABA) is a behavior intervention model to treat children with autism spectrum disorder (ASD). ABA is offered to Medicaid-eligible individuals under age 21 in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT). ABA services include: • Assessment • Evaluation/reevaluation • Treatment intervention plan with measurable objective goals

COVERED SERVICE	ADDITIONAL INFORMATION
	• Targeted goals (data driven) • Functional communication training • Self-monitoring skills • Adaptive living skills • Cognitive skills • Speech, occupational, physical therapy • Durable Medical Equipment (DME) • Speech Generating Device (SGD) • Verbal skills • Language skills • Peer play • Social skills • Pre-vocational and vocational skills • Parent training • Family education • Family counseling • Case management
ASSISTANT SURGEON	An assistant surgeon aids the performing surgeon during a surgical procedure. These services are covered for qualifying procedures.
ASSISTIVE/AUGMENTATIVE COMMUNICATION DEVICES	Devices, such as speech synthesizers, that help members with limited vocal or verbal communication skills convey their thoughts.
AUDIOLOGY SERVICES	These services help decide whether a person can hear within the normal range and, if not, which parts of hearing have changed and to what degree. If an audiologist diagnoses a hearing loss, he or she will advise what options may help a patient (e.g., hearing aids, cochlear implants, surgery). Anthem covers: • Medically needed hearing aids • Hearing aids and supplies made during a Healthy Kids checkup, for members under age 21 in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Certain limits apply.

COVERED SERVICE	ADDITIONAL INFORMATION

BEHAVIORAL HEALTH
 	
BEHAVIORAL HEALTH (Cont.)
	Covered services up to limits outlined in the Ohio Medicaid and Healthchek program include:
	• Crisis Intervention for members who go through a psychiatric crisis to:
	    • Reduce symptoms.
	    • Help stabilize and restore a person to his or her former level of function.
	• Crisis Stabilization to help a person in crisis return to his or her prior level of function.
	• Prescribed Electroconvulsive Therapy to treat severe mental illness.
	• Hospital-based Detoxification/Chemical Dependency. Services:
	    • Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol.
	* Certain limits apply as determined by the Ohio Medicaid and Healthchek program.
	• Inpatient Professional Services given within an inpatient setting by:
	    • Psychiatrists
	    • Psychologists
	    • Clinical social workers
	    • Therapists
	    • Medical doctors or specialists
	    • Certified Nurse Practitioners
	• Intensive Outpatient Program for psychiatric and chemical dependency that:
	    • Meets several times a week for at least three hours of mental health or substance/alcohol abuse services.
	    • Aims to improve a person's level of function to prevent a relapse or hospital admission.

COVERED SERVICE	ADDITIONAL INFORMATION

BEHAVIORAL HEALTH (Cont.)	• Medication Assisted Treatment such as a Methadone Maintenance Program for the treatment of heroin addiction.
	• Neurotherapy — also referred to as neurofeedback or EEG biofeedback — is a process to observe the central nervous system and the brain. This allows for a better understanding of possible irregularities in the brain, and treatment can train the brain to correct the irregularities.
	  ◦ Hospital observation services.
	• Outpatient/ambulatory detox and/or rehab services:
	  ◦ Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol.
	• Outpatient mental health/substance abuse services include:
	  ◦ Basic medical and therapeutic services
	  ◦ Crisis services
	  ◦ Review and diagnosis of care
	  ◦ Individual, family and/or group therapy, unless part of an EPSDT screening
	  ◦ Medication management
	You may receive these services from authorized physicians, psychologists, or other mental health professionals.
	• Partial Hospital, Psychiatric and Chemical Dependency Treatment programs that:
	  ◦ Are offered Monday through Friday for at least six hours each day.
	  ◦ Are provided by a hospital in an outpatient setting.
	  ◦ Provide a range of psychiatric and substance abuse treatment services.

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	• Offer partial hospital care as an alternative to inpatient psychiatric or substance abuse care. • Psychosocial rehabilitation services/basic skills training to help reach or maintain a person's greatest level of function. • Make the most of their personal strengths. • Develop ways to cope and deal with areas of weakness. • Build a supportive environment in which to function. • Psychological and neuropsychological testing that is used by psychologists to test: • Mood • Personality type • Learning skills These tests can be used to help decide a mental health diagnosis. Covered services include: • Neuropsychological testing • Neurobehavioral testing • Psychological testing • Residential treatment center (RTC) Alcohol and drug abuse to residents who do not require acute medical care • Mental health to children and adolescents who do not need intense acute inpatient care Services include: • Individual, group and family therapy • Medication management • Medical treatment • Lab testing

COVERED SERVICE	ADDITIONAL INFORMATION
BEHAVIORAL HEALTH (Cont.)	• Room and board **Healthchek members through their 19th birthday** Anthem covers medically needed care (physician services, lab work, dental, X-ray services, etc.) and professional services provided in an RTC. Healthchek covers the admission and daily room rate. **Medicaid members age 21 and older** Anthem will cover services for the first month of admission. On the first day of the month after admission, the member will be disenrolled from Anthem and receive all Medicaid-covered services from the fee-for-service program.
BIOFEEDBACK (AS PART OF NEUROTHERAPY) **Neurotherapy** — also referred to as neurofeedback or EEG biofeedback — is a process to observe the central nervous system and the brain. This allows for a better understanding of possible irregularities in the brain, and treatment can train the brain to correct the irregularities. **Biofeedback** treatment helps train people to improve their health by using signals from their own bodies. • Physical therapists use it to help stroke victims regain movement in paralyzed muscles. • Specialists use it to help their patients cope with pain. • Psychologists use it to help a tense and anxious individual learn to relax.	**Neurotherapy** — Anthem covers medically needed neurotherapy when given by a licensed qualified mental health professional (QMHP) within the scope of his or her practice. **Biofeedback** — A certified biofeedback technician may assist in giving biofeedback treatment, but a QMHP must provide the related psychotherapy. Certain limits apply.
BLOOD ADMINISTRATION AND OTHER BLOOD PRODUCTS	Anthem covers injecting of blood or blood products into a vein or artery.

COVERED SERVICE	ADDITIONAL INFORMATION
BOTOX INJECTIONS	Covered services include treatment for jerkiness of limbs as a result of a brain or spinal cord injury, including cerebral palsy. Treatment for cosmetic purposes is not covered.

CARE MANAGEMENT	Care management is designed to respond to a member's needs when the member's condition or diagnoses require care and treatment for short and long periods of time.
	
	When a member is in a care management program:
	• An Anthem care manager or care guide helps identify settings in which care may be given.
	• A provider, on behalf of the member, may request the member take part in the program. The care manager or care guide will work with the member and the member's providers to decide:
	    • The level and types of services needed.
	    • Other settings where care may be given.
	    • Equipment and/or supplies needed.
	    • Nearby community-based services.
	    • Communication needed between the member and the member's care team, such as the PCP and specialists.
	
	Care managers will complete member screening and assessment tools to help identify holistic care needs, and gaps in care.
	
	The Comprehensive Health Assessment includes:
	• A range of questions to identify and assess the member's:

COVERED SERVICE	ADDITIONAL INFORMATION
CARE MANAGEMENT (Cont.)	- Immediate care needs and current services in place. - Physical Conditions - Behavioral Health Conditions, including substance use status. - Functional limits. - Cultural preferences. - Community resource needs. - Available supports in place, such as caregivers. - Special health needs. - Exposure to adverse childhood experiences or trauma. - Current treatment plan. • Phone interviews or home visits to collect and assess information received from members or their representatives; to complete the assessment. Care managers will also receive information from: - The member's PCP and specialists. - The member's family if applicable, such as a legal representative of the member. - Other care team members to help collaborate on the Member's current medical and nonmedical service needs. **Individualized plan of care** Care managers will use information from the assessment to help the Member and their care team decide the proper care management services needed. The care manager will: • Work with the Member, their family (when applicable), and the Member's

COVERED SERVICE	ADDITIONAL INFORMATION
CARE MANAGEMENT (Cont.)	providers to develop and set up the proper care plan. • Think of the Member's needs for social, educational, therapeutic and other nonmedical support services as well as the strengths and needs of the Member and their family. When nonmedical needs are complex, care managers or care guides will work with: • Social workers • Patient navigators • Community health workers • Community based organizations • Peer support specialists Member advocates or outreach specialists may attempt to contact members for Care Management Services. If a member is receiving care management services from other sources (e.g., a community services organization, other care management services, or OhioRise), the care plan will define: • The process for managing medical, behavioral health, and/or substance abuse, and social aspects of care. • The roles of each person on the care team. A signed member release may be needed in certain situations to openly discuss specific health concerns with the Member's care team, including their PCP.

COVERED SERVICE	ADDITIONAL INFORMATION
CHEMOTHERAPY AND RADIATION	**Chemotherapy** is the use of drugs to kill bacteria, viruses, fungi, and — most often — cancer cells. • It can destroy cancer cells at sites great distances from the original cancer. • More than half of all people diagnosed with cancer receive chemotherapy. A **chemotherapy regimen** is a treatment plan and schedule that includes drugs to fight cancer, plus drugs to help support finishing the cancer treatment at the full dose or schedule. **Radiation therapy** is the use of a certain type of energy, called ionizing radiation, to kill cancer cells and shrink tumors. • In some cases, the goal of radiation treatment is to destroy an entire tumor. • In other cases, the goal is to shrink a tumor and relieve symptoms. In both cases, doctors plan treatment to spare as much healthy tissue as possible.
CHIROPRACTIC SERVICES	For Medicaid members under age 21 and Healthchek members through their 19th birthday. Covered services include: Medically needed chiropractic services when referred to a chiropractor as part of a Healthy Kids checkup, and when a diagnosis of spinal subluxation is made by the referring doctor.
CIRCUMCISION	Circumcision is a covered benefit.
CLINICS	**Federally qualified health centers (FQHCs)** provide preventive services, or services to treat an illness or chronic disease. **Rural health clinics (RHCs)** provide preventive services.

COVERED SERVICE	ADDITIONAL INFORMATION
	Members can receive covered services at these facilities from the following providers: • Physicians • Nurse practitioners • Physician assistants • Certified nurse-midwives • Visiting nurses • Clinical psychologists • Clinical social workers • Registered dietitians • Nutritional professionals **You can receive these services without a referral from your PCP.**
COCHLEAR IMPLANTS	These devices: • Help capture, analyze, and code sound. • Help a person identify and be aware of sounds. • Aid in communication for persons who are extremely hard of hearing.
COSMETIC/PLASTIC/RECONSTRUCTIVE SURGERY PROCEDURES	**Cosmetic surgery**, performed to reshape normal structures of the body to improve a person's appearance and self-esteem, is not a covered benefit. **Reconstructive surgery,** performed on abnormal structures of the body caused by birth defects, developmental abnormalities, trauma or injury, infection, tumors or disease, may be covered. Reconstructive surgery is usually done to improve function, but in some cases may also be done to help come close to a normal appearance. This may include cleft palate repair, breast reconstruction, etc. Covered reconstructive surgery services include: • Surgery for the prompt repair of an injury caused by an accident. • Surgery to improve a malformed body part in order to improve function.

<table>
<tr><th>COVERED SERVICE</th><th>ADDITIONAL INFORMATION</th></tr>
<tr><td>DENTAL SERVICES</td><td>Call DentaQuest at 888-291-3762
(TTY 800-466-7566) for information about receiving dental services.</td></tr>
<tr><td>DERMATOLOGY</td><td>Dermatology is the science that treats the skin and its structure, function and diseases, including the hair and nails. Anthem covers this service.</td></tr>
<tr><td>DIABETIC SERVICES

DIABETIC SERVICES (Cont.)</td><td>Services include:
Screenings, which consist of lab tests for members who have certain risk factors for diabetes or who are diagnosed with prediabetes.
Training to teach members to self-manage their diabetes; the program includes:
Instructions on how to self-monitor blood glucose.
Training on diet and exercise.
An insulin treatment plan specifically for the person who is insulin-dependent.
Reasons for patients to use skills for self-management.
Supplies to self-test glucose levels of the blood to monitor and control diabetes including:
Glucometers
Syringes
Lancets
Needles</td></tr>
<tr><td>DIAGNOSTIC TESTING</td><td>Diagnostic testing includes:
Laboratory and radiology services including, but not limited to:
Blood chemistry
Pathology testing: microbiology and other testing using physical specimens such as tissue, urine or blood
Bone mass/density studies</td></tr>
</table>

COVERED SERVICE	ADDITIONAL INFORMATION
DIAGNOSTIC TESTING (Cont.)	• Testing for human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) • Lead blood screenings • Prostate-specific antigen testing (PSA) • Sleep studies • Portable X-ray services • Preadmission tests • Colorectal cancer screening procedures • Positron emission tomography (PET) scans • Nuclear medicine services include procedures and tests performed by a radioisotope lab using radioactive materials such as: • Computed tomography (CT) • Magnetic resonance imaging (MRI) • Cardiac testing
DIALYSIS SERVICES	Dialysis services are given to remove toxic materials and maintain fluid balances in cases of poor kidney function. Covered services include: • Home dialysis managed by the patient or a patient's representative under the guidance of a freestanding clinic. • Services received in an inpatient or outpatient hospital setting.

COVERED SERVICE	ADDITIONAL INFORMATION
DISPOSABLE MEDICAL EQUIPMENT	Anthem covers medically needed disposable supplies that would not generally be useful to a person without an illness or an injury. Members should ask their PCP if they need disposable medical equipment.
DURABLE MEDICAL EQUIPMENT	Durable medical equipment is equipment: • Used to serve a medical purpose. • Fitted for use in the home. • Able to withstand repeated use. Covered services as determined by the Ohio Medicaid and Healthchek program include: • Certain medically needed equipment (e.g., crutches, wheelchairs, ventilators, etc.). • Items that would not generally be useful to a person without an illness or an injury.
DURABLE MEDICAL EQUIPMENT (Cont.)	Members should ask their PCP if they need durable medical equipment. Anthem does not cover: • Physical fitness or personal recreation equipment • Personal care or hygiene products • Household items such as air conditioners and ceiling fans • Environmental products • TDD devices.

COVERED SERVICE	ADDITIONAL INFORMATION
EARLY CHILDHOOD INTERVENTION (ECI) SERVICES	These services assist families with children ranging from birth to school age that have developmental disabilities and delays. The program provides screening and resource referral methods that support families in helping affected children reach their potential through developmental services.

COVERED SERVICE	ADDITIONAL INFORMATION

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) SERVICES (MEDICAID)/ WELL-BABY/WELL-CHILD SCREENINGS (HEALTHCHEK)	The Healthchek EPSDT program covers screening, diagnosis, and treatment services to members under the age of 21. Services include all mandatory and medically necessary services (including treatment) to correct or improve any physical or mental health conditions discovered through screening. **This program is known as "Healthy Kids" in Ohio.**
	
	Covered services include:
	• Complete medical screenings, including:
	  ◦ Complete health and development history with assessment for both physical and mental health development
	  ◦ Complete physical exam
	  ◦ Proper immunizations (shots) according to age and health history
	  ◦ Lab tests, including lead blood level assessment
	  ◦ Health education
	  ◦ Vision screening
	  ◦ Hearing screening

EMERGENCY SERVICES	Emergency services include inpatient and outpatient services by a qualified provider to assess or stabilize an emergency medical condition. See the section **Different Types of Healthcare** under the heading **Emergency Care** for more details.
ENTERAL NUTRITION	• Enteral nutrition, also called tube feeding, is a way to provide food through a tube placed in the nose, stomach, or small intestines.
FAMILY PLANNING	Anthem covers family planning services for members of childbearing age. Members can receive family planning services from plan or non-plan providers. Services include:

<table>
<tr><th>COVERED SERVICE</th><th>ADDITIONAL INFORMATION</th></tr>
<tr><td>FAMILY PLANNING (Cont.)</td><td>Education
Counseling
Physical exams
Birth control devices, implants, medication, and supplies
Members do not need a referral for family planning services. See the Family Planning Services section under the heading Special Kinds of Healthcare for more details.

The following services are not covered:
Tubal ligations and vasectomies for people who are:
Under age 21
Mentally incompetent
Institutionalized
Sterilization reversals
Abortions (These services are excluded from family planning but may be covered under certain conditions; for example, to save the life of the mother, for rape or incest, or if medically necessary. Your provider will explain these services and ask you to sign a consent form.)</td></tr>
<tr><td>GASTROENTEROLOGY SERVICES</td><td>Gastroenterology is a branch of medicine concerned with the structure, functions, diseases, and pathology of the stomach and intestines.</td></tr>
</table>

COVERED SERVICE	ADDITIONAL INFORMATION
GENETIC AND DNA TESTING	Genetic and DNA testing is considered medically needed to establish a diagnosis of inherited diseases when certain conditions are met. Covered services include: • Assessing if there is a genetic disorder. • Diagnosing such disorders. • Counseling and following up with members with known or supposed disorders. Anthem does not cover: • Prenatal diagnosis to find out the sex of the baby unless there is reason for genetic disease • Self-testing home kits • Genetic testing for cleft disorders • Experimental genetic testing • Blood typing for paternity testing.
HIV/AIDS CARE	Anthem covers: • Standard diagnostic tests to diagnose HIV infection • Medications to treat HIV infection Anthem does not cover experimental or investigational studies or treatments.
HOME HEALTHCARE	Anthem covers medically needed home healthcare services provided at a member's home if services are clearly defined as part of an approved plan of care. Covered services include: • Personal care services • Home environment evaluation • Skilled nursing services

COVERED SERVICE	ADDITIONAL INFORMATION
	• Home health aide services • Dietitian services • Respiratory therapy • Physical therapy (limit restrictions apply) • Occupational therapy (limit restrictions apply) • Speech therapy (limit restrictions apply)
HOME INFUSION/TOTAL PARENTERAL NUTRITION (TPN)	Services provided by a licensed nurse to administer drugs, intravenous fluids, or total parenteral nutrition (TPN) through an intravenous catheter. TPN is given to people who are not able to absorb nutrients through the intestinal tract.
HOSPITAL INPATIENT MEDICAL AND SURGICAL	Anthem covers inpatient hospital care for medically necessary conditions. Inpatient hospital services include: • Room and board • Nursing and provider services • Diagnostic or therapeutic services • Medical or surgical treatments and supplies • Medication given while in the hospital
HOSPITAL OUTPATIENT	Anthem covers outpatient hospital services.
HYPERBARIC OXYGEN (HBO) THERAPY	Hyperbaric oxygen (HBO) therapy treats: • Carbon monoxide poisoning • Air embolism • Smoke inhalation • Acute cyanide poisoning • Decompression sickness • Certain cases of blood loss or anemia where increased oxygen may help balance the blood deficiency • Topical HBO therapy is not covered
HYSTERECTOMY	Anthem covers medically necessary hysterectomies. Your provider will require

COVERED SERVICE	ADDITIONAL INFORMATION
	you to sign a consent form. A hysterectomy performed for the sole purpose of sterilization is not covered.
NUTRITION/DIETITIAN SERVICES	Anthem covers medically necessary services to address nutrition related issues for Medicaid recipients. To receive nutrition/dietician related services, members must have written orders of a physician, physician assistant (PA) or advanced practice registered nurse (APRN). A registered dietitian must design and approve the treatment. Certain limitations apply.
MEDICAL REHABILITATION CENTER OR SPECIALTY HOSPITAL	Anthem covers medically needed services provided at freestanding rehab hospitals, or a rehab unit of a general hospital. Anthem also covers care provided in a freestanding long-term acute care hospital, or a long-term acute care unit of a general hospital.
BARIATRIC SURGERY/OBESITY SURGERY	Bariatrics is a branch of medicine to help prevent, control, and treat obesity. **Obesity surgery/bariatric surgery** is a weight-loss method limited to people who meet the eligibility and medical necessity requirements. Anthem will cover services up to limits as outlined in the Medicaid and Healthchek program.

<table>
<tr><th>COVERED SERVICE</th><th>ADDITIONAL INFORMATION</th></tr>
<tr><td>OPHTHALMOLOGY/OPTOMETRY SERVICES (VISION SERVICES)</td><td>Covered services include:
• One complete eye exam every 12 months
• Refractive exams
• Frames
• Lenses
• Fitting, dispensing, and adjustment of glasses
• Follow-up exams
• Contact lenses (in certain circumstances)</td></tr>
<tr><td>OUTPATIENT SURGERY</td><td>Anthem covers medically needed outpatient surgery.</td></tr>
<tr><td>PERSONAL CARE SERVICES</td><td>Anthem covers personal care services given to members who need help with daily living and meet the eligibility requirements. These services are given at certain times and as described in the Ohio Medicaid program.

Covered services include:
• Help with bathing, grooming, or dressing
• Help with toileting needs
• Help with transferring and positioning people who cannot walk
• Help with walking
• Help with eating
• Help with taking medicines

The following services are not covered:
• Tasks a person is able to perform
• Services given by willing caregivers
• Tasks that aren’t on the approved service plan
• Services to maintain a household
• Services given to a person other than the planned receiver</td></tr>
</table>

COVERED SERVICE	ADDITIONAL INFORMATION
	• Care is required to be given by a healthcare professional approved by the state
PHYSICIAN SERVICES	Anthem covers medically needed care provided by a: • Certified nurse-midwife • Certified registered nurse practitioner • Nurse anesthetist • Physician/osteopath • Physician assistant Ask your PCP if you think you need to see one of these providers.
PODIATRY SERVICES	Anthem covers medically needed podiatry care for all Medicaid eligible individuals.
POST-STABILIZATION CARE	Post-stabilization care services are Medicaid-covered services you receive after emergency medical care. You receive these services to help keep your condition stable after you have an emergency.
REHABILITATIVE THERAPY (PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY)	Anthem covers therapy to treat illness or injury that keep people from doing their daily activities. Therapy is provided only for problems that are expected to improve in a reasonable period of time. Therapy is not covered just for exercise or fitness.
SKILLED NURSING CARE	Anthem covers the first 180 days of medically needed care in a nursing facility. On the 181st day, you — the member — will be disenrolled from Anthem. The rest of your stay will be covered by Ohio Medicaid.
SMOKING CESSATION PROGRAMS/SUPPLIES	Anthem covers products to help you stop smoking, including: • Over-the-counter (OTC) patches • Gums • Lozenges • Inhalers • Tablets

COVERED SERVICE	ADDITIONAL INFORMATION
	These products are available with a prescription from your PCP. These products do not require Prior Authorization. Certain limitations apply.
SPECIAL CARE MANAGEMENT ***SED or SMI Determinations**	Anthem covers special care management services for the following groups: • Adults with special healthcare needs • Children with special healthcare needs • Children and adolescents who are severely emotionally disturbed (SED)* • Adults with serious mental illness (SMI)* • Infants and toddlers with developmental delays A care manager will help: • Assess and evaluate healthcare needs. • Develop a plan of care. • Receive referrals and needed services. • Coordinate services between PCPs and specialists. • Monitor care and follow-up. *** SED or SMI determination must be completed by a qualified Anthem provider.** **Upon determination, Medicaid members** who are diagnosed as being SED or SMI can choose to disenroll from Anthem and continue to receive benefits through Medicaid. **Healthchek members** diagnosed as SED or SMI do not have the option to disenroll and will continue to receive covered services through Anthem. Annually, Medicaid and Healthchek members diagnosed as SED or SMI will be evaluated, and a new determination will be made. If the evaluation does not result in a redetermination as SED or SMI, the Medicaid member who

COVERED SERVICE	ADDITIONAL INFORMATION
	chose to disenroll from Anthem will be re-enrolled as of the first day of the next possible month.
SWING BEDS	A swing bed is a bed in a rural or critical access hospital that can be used to provide either standard hospital care or skilled nursing care. Anthem covers the first 45 days of care from a swing bed in an acute hospital, when medically needed. Once the stay goes over 45 days, the member will be disenrolled from Anthem. The rest of the stay will be covered by Healthchek or Medicaid.
TELEHEALTH (LiveHealth Online)	LiveHealth Online allows you to see a doctor through a video chat session on your smartphone, tablet, or computer with a webcam. Your video chats are private and secure. It's a convenient way to see the doctor when it is late at night, you cannot make it to the doctor's office, or you need an appointment fast.
TEMPOROMANDIBULAR JOINT	Covered for recipients age 20 years and younger. TMJ services may be provided by a dentist or medical doctor. Surgery to correct a wide range of diseases, injuries, and defects to the head, neck, face, jaw, and hard and soft tissues of the lower jaw and face region is covered.

COVERED SERVICE	ADDITIONAL INFORMATION
TRANSPLANTS	Anthem covers the following transplants for Medicaid-eligible adults (21 and older) when medically needed and not experimental: • Cornea • Kidney • Liver • Bone marrow Anthem covers any medically needed transplant that is not experimental for: • Medicaid members under age 21 • Healthchek members through their 19th birthday

Anthem value-added benefits

Anthem also offers extra services and/or benefits (value-added benefits) to their members. Please see the list below that explains these extra services.

Anthem value-added benefits:

- Baby essentials — eligible members can select up to two options from a customized catalog filled with essential baby items such as:
    - Boppy pillow
    - High chair
    - Booster seat
    - Portable crib
    - Car seat
    - Breastfeeding support kit
    - Safe sleep kit

- Mail-order diapers — eligible members can receive up to $75 worth of free diapers shipped directly to their home free of charge.

- Organic baby food — to help ensure our youngest members have access to the nutrition they need, we will provide eligible members $30 in organic baby food.

- Post-discharge meals — Anthem will provide home-delivered, medically tailored meals to eligible members with food insecurities and key, chronic medical conditions, including congestive heart failure (CHF), cancer, chronic obstructive pulmonary disease (COPD), diabetes, HIV/AIDS, and end stage renal disease (ESRD), and pregnant and postpartum members with gestational diabetes.

- Anthem will provide students 6-18 years of age with tutoring support across a variety of school subjects.

- Laptop computer — eligible members will be able to receive a no-cost laptop to help with employment and educational pursuits.

- Childcare — up to $100 towards childcare for eligible members who enroll in an employment support program.

- Industry certification assistance — Anthem will support employment certifications for eligible members who are interested in obtaining them through a $100 gift card. Members may also be eligible for additional certification cost coverage through employment and education flex funds.

- SUD recovery support — eligible members will receive access to our SUD Recovery Support Program, which is a mobile platform that provides daily motivations/check in, peer support through discussion groups and peer to peer messages, counselor messaging, care plan reminders, goals, journals, high risk location alerts, and content to support ongoing recovery.

- OTC supplies — eligible members will receive up to $100 allowance a year to purchase OTC products online or in-store. Members can choose between a $25.00 quarterly Health and Wellness voucher (redeemable at Amazon.com) or a $25 CVS Select Gift card (redeemable at CVS pharmacy locations).

- Transportation essentials (these benefits are in addition to the required transportation benefits):
  - Medical and community transportation — eligible members will receive transportation services (up to 30 round trips or 60 one-way trips) to provider appointments less than 30 miles or to community resources and services.
  - Ride Share gift card — eligible members will receive one $25 Ride Share gift card to help them with their transportation needs.

- Online well-being program — eligible members will receive access to our online well-being program, a web and mobile online community designed to help members cope with emotional health issues such depression, anxiety and stress, chronic pain, insomnia, and managing drugs or alcohol.

- Enhanced dental — in addition to the covered benefit, eligible adult members will receive one additional cleaning, one additional X-ray, and scaling and root-planning services.

- Vision benefit:
  - Eligible members up to age 21 will receive $100 allowance towards purchase and fitting of contact lenses or an additional pair of eyeglasses per calendar year. No copays will apply.

  - Eligible members ages 21 to 59 will receive one (1) comprehensive eye exam and $100 allowance towards purchase and fitting of contact lenses or an additional pair of eyeglasses per calendar year. No copays will apply.

- To redeem your rewards, log in to the Anthem Benefit Reward Hub at **anthem.com/oh/medicaid** and visit the *Rewards* page. From the *Rewards* page, select **Redeem** and choose a gift card.

Anthem Healthy Rewards

Healthy Rewards is a no-cost, optional program for health plan members. The program encourages you to get the care you need to create a healthy lifestyle and then rewards you for completing healthy activities.

You may be eligible to earn these Healthy Rewards through the Benefit Reward Hub within your health plan account at **anthem.com/oh/medicaid**.

Members must enroll in the Healthy Rewards program to earn rewards.

- If you need help creating your health plan online account, please reach out to Member Services at **844-912-0938 (TTY 711)** for assistance.

Healthy Rewards offered:

- Pregnant Women and New Moms:
  - Up to $95 for completing prenatal and postpartum care visits, including a bonus new mom maternity reward.
  - $100 for completing eight well-child visits, ages 0-30 months including a bonus well child and vaccine reward.

- Child Wellness:
  - $10 for completing the combo 10 vaccine before age 2.
  - Up to $20 when you refill Asthma medication.
  - $10 for completing a lead screening (blood test) before age 2.
  - $10 for completing child and adolescent wellness visits.

- Healthy Lifestyle and Preventative Care:
  - Up to $40 for diabetic screenings.
  - Up to $40 when you refill diabetic medication.
  - Up to $50 for women's preventative screenings (breast and cervical cancer & chlamydia).
  - Up to $40 for tobacco cessation programs and completion.
  - Up to $45 for completing an annual health screener and dental visit.

- Mental Health:
  - $20 for follow-up with the doctor after a hospital stay.
  - $20 for screening and testing for members taking antipsychotic medication.

To redeem your rewards, log in to the Anthem Benefit Reward Hub at **anthem.com/oh/medicaid** and visit the Healthy Rewards page. From the *Healthy Rewards* page, select **Redeem** and choose a gift card.

SERVICES NOT COVERED BY ANTHEM

Anthem will not pay for services or supplies received that are not covered by Medicaid:

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

If you have a question about whether a service is covered, please call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

SERVICES NOT COVERED BY ANTHEM UNLESS MEDICALLY NECESSARY

Anthem reviews applicable State regulations and conducts a medical necessity review, if appropriate. Anthem 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 saving 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
- Services for the treatment of obesity
- Services determined as not medically necessary by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

FREQUENCY LIMITATIONS

Your managed care organization will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

SERVICES THAT DO NOT NEED A REFERRAL

You do not need a referral or service authorization to get:

- Care from your primary care provider (PCP).
- Family planning services and supplies. You can also visit any family planning provider, even if the provider is not part of the Anthem network.

- Routine women's healthcare services like breast exams, screening mammograms, pap tests, and pelvic exams, as long as you get them from a network provider.
- Emergency or urgently needed services.
- Routine dental services.
- Routine eye care services.
- Care from behavioral health specialist, as long as you get them from a network provider.
- Preventive services, or services to treat an illness or chronic disease from Federally qualified health centers (FQHCs).
- Preventive services from rural health clinics (RHCs) provide preventive services.
- Other services for members with special healthcare needs as determined by the Anthem plan.

NEW TECHNOLOGY

Advances in medical technology bring new treatments to the market all the time. We want to make sure you have access to medical and behavioral health treatments that are safe and effective. So, we review them to make sure they are safe and effective, and they work the way they are supposed to.

We use the following in our review process:

- Scientific literature
- Peer-reviewed medical journals
- Nationally recognized guidelines by accredited medical specialty societies
- Current medical community standards
- Government regulatory bodies, such as the Food and Drug Administration (FDA)
- Medical experts in the condition the new treatment is for

DIFFERENT TYPES OF HEALTHCARE

Routine, urgent, and emergency care: what is the difference?

Routine care

In most cases, when you need medical care, you visit your PCP. This type of care is known as **routine care**. Some examples are most minor illnesses and injuries and regular checkups. You should be able to see your PCP within two weeks for routine care.

Your PCP also provides care that can prevent you from getting sick. This is called wellness care, and includes checkups, shots, and screenings. See the section in this handbook **Wellness Care for Children and Adults**.

Urgent care

Some injuries and illnesses are not emergencies but can turn into emergencies if not treated within 24 hours. This type of care is called **urgent care**. Some examples are:

- Throwing up and diarrhea
- Minor burns or cuts
- Earaches

- Headaches
- Sore throat
- Fever over 101 degrees
- Muscle sprains/strains and joint pain
- Backaches
- Pain with urination
- Coughs, colds, and flu

If you need urgent care:

- Call your PCP. Your PCP will tell you what to do.
- Follow your PCP's instructions. Your PCP may tell you to go to:
    - His or her office right away.
    - Some other office to receive immediate care.
- An urgent care location. You can find urgent care locations by using the Find Care tool at **findcare.anthem.com/search-providers**.
    - Use LiveHealth Online at **livehealthonline.com**.

You can also call 24/7 NurseLine at **844-430-0341 (TTY 711)** if you need advice about urgent care. You should be able to see your PCP within two days for an urgent care appointment.

Emergency care

Emergency services

Emergency services are for a medical problem that must be treated right away by a provider. We cover care for emergencies both in and out of the county where you live. Some examples of when emergency services are needed include miscarriage/pregnancy with vaginal bleeding, chest pain (suspected heart attack), breathing difficulties, severe trauma (injury) or burns, unconsciousness (example: suspected drug overdose), stroke (sudden onset of physical impairment) or seizures.

You do not have to contact Anthem before you get emergency services. If you have an emergency, call **911** or go to the nearest emergency room (ER) or other appropriate care setting.

If you are not sure if you need to go to the ER, call your primary care provider (PCP), or 24/7 NurseLine at **844-430-0341 (TTY 711)**. Your PCP or 24/7 NurseLine can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Tell them that you are a member of Anthem and show them your Anthem member ID card.
- If the provider treats your emergency, thinks you need other medical care to treat the problem that caused your emergency, the provider must call Anthem.

- Anthem will assign a case manager who will be responsible for supporting the member through the transition and notification of the assignment within two (2) business days of notification of discharge.
- If the hospital has you stay, make sure that Anthem is called within 24 hours.

What is an emergency? An emergency is anything that could cause very serious harm or death if not treated immediately. This means someone with an average knowledge of health and medicine can tell the problem may threaten your life or cause serious harm to you or your unborn child if you are pregnant. Here are some examples of problems that are most likely emergencies:

- Trouble breathing
- Chest pains
- Loss of consciousness
- Very bad bleeding that does not stop
- Very bad burns
- Shakes called convulsions or seizures
- Unable to walk or talk
- Mental health crisis or feeling like hurting yourself or hurting someone else

If you have an emergency, do one of the following:

- Call **911**.
- Go to the nearest hospital emergency room. The hospital does not need to be a part of the Anthem plan for you to receive emergency care. You will be able to continue to receive care until your health has stabilized.
- Go to an urgent care center.

You should be able to see a physician right away. You do not need a referral from your PCP or another provider to receive emergency care.

- Be sure to tell the hospital staff you are an Anthem member.

If you want advice about emergency care, call your PCP or 24/7 NurseLine at **844-430-0341 (TTY 711)**. Treatment for medical emergencies does not need pre-approval by Anthem.

After you visit the emergency room, it is important to call your PCP as soon as possible. If you cannot, have someone else call for you.

- Contact your PCP as soon as you can. Your PCP can:
    - Arrange your ongoing treatment.
    - Help you receive needed hospital care.

It may be necessary for you to receive additional care to keep your condition stable after an emergency. This type of care is referred to as post-stabilization care. Post-stabilization care is a covered service unless you are out-of-state and/or out-of-network.

How to receive healthcare when your doctor's office is closed

Except in the case of an emergency or when you need care that does not need a referral, you should always call your PCP **first** before you receive medical care. If you call your PCP's office when it is closed, leave a message with your name and a phone number for a return call. If it is not an emergency, someone should call you back soon to tell you what to do. You may also:

- Call 24/7 NurseLine to speak to a nurse 24 hours a day, seven days a week.
- Use LiveHealth Online to video chat with a doctor any time, day or night, to receive quick care for minor illnesses like colds, allergies, flu, or infections.
- Call our 24/7 Behavioral Health Crisis Line 24 hours a day, seven days a week at **844-912-2425**.
- If you think you need emergency services, call **911** or go to the nearest emergency room right away.

How to receive healthcare when you are out of town

- If you need emergency services when you are out of town, go to the nearest hospital emergency room or call **911**.
- If you need urgent care:
  - Call your PCP. If your PCP's office is closed, leave a phone number where you can be reached. Someone should call you back within 30 minutes.
  - Follow your PCP's instructions. You may be told to receive care right away.
  - Call 24/7 NurseLine.
  - Call our 24/7 Behavioral Health Crisis Line
- If you need routine care like a checkup or a prescription refill:
  - Call your PCP.
  - Call 24/7 NurseLine.

*** If you are outside of the United States and receive healthcare services, they will not be covered by Anthem or fee-for-service Medicaid.**

How to receive healthcare when you can't leave your home

If you cannot leave your home, we will find a way to help take care of you. Call Member Services right away. We will put you in touch with a case manager who will help you receive the medical care you need.

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 Member Services 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, another insurance company may have to pay for the care or services you received. When you call us give the name of the person at fault, their insurance company and the name(s) of any attorney(s) involved.

WELLNESS CARE FOR CHILDREN AND ADULTS

All Anthem members need to have regular wellness visits, including checkups and screenings, with their primary care provider (PCP). Your PCP will provide care based on nationally accepted guidelines. During a wellness visit, your PCP may detect problems before they worsen. When you become an Anthem member, make an appointment with your PCP within 90 days.

When you or your child misses one of your wellness visits

If you or your child does not go to a wellness visit on time:

- Make an appointment with the PCP as soon as you can.
- Call Member Services if you need help setting up the appointment.

If your child has not visited his or her PCP on time, we will send you a postcard reminding you to make your child's well-child appointment.

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 members under the age of 21 years old. These exams make sure that children are healthy and are developing physically and mentally. The Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care, also known as the "Periodicity Schedule," recommended at each well-child visit from infancy through adolescence. 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.

Healthchek covers medical, vision, dental, hearing, nutritional, developmental, behavioral health exams, and other care to treat physical, behavioral, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek is available at no cost to members and includes:

- Preventive checkups for newborns, infants, children, teens, and young adults under the age of 21.
- Healthchek screenings:
  - Medical exams (including physical and development screenings)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing
- Laboratory tests (age and sex appropriate exams)
- Immunizations

- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to:
    - visits with a primary care provider, specialist, dentist, optometrist and other Anthem providers to diagnose and treat problems or issues
    - inpatient or outpatient hospital care
    - clinic visits
    - prescription drugs
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early. That way your provider can treat them, or make a referral to a specialist for treatment before the problem gets more serious. *Remember: Some services may require a referral from your PCP or prior authorization by Anthem.* For some EPSDT items or services, your provider may ask for prior authorization for Anthem to cover things that have limits or are not covered for members over the age of 20. Please see page 12 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 who have special health care needs. Please see page(s) 60 to learn more about the care management services offered by Anthem.

How to get Healthchek services

Call your doctor or dentist to schedule an appointment for a Healthchek exam. Make sure to ask for a Healthchek exam when you call your PCP. You should try to schedule the first exam within 90 days of becoming a member.

If you would like to learn more about the Healthchek program, please call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time. We can help you:

- Access care.
- Find a provider.
- Make an appointment.
- Find out what services are covered, and which ones may need prior authorization.
- Arrange transportation (a ride), if needed.
- Get referrals for Women, Infant and Children (WIC), Head Start, Help me Grow, bureau for children with medical handicaps (BCMH) and community services such as food, heating assistance, housing and employment services, and more.

Immunizations (shots)

It is important for your child to have shots on time. Follow these steps:

1) Take your child to the PCP when they needs shots.
2) Use the chart on the next page to help keep track of the shots your child needs.

Range of recommended ages for all children

<table>
<tr><th>VACCINE</th><th>BIRTH</th><th>1 MONTH</th><th>2 MONTHS</th><th>4 MONTHS</th><th>6 MONTHS</th><th>12 MONTHS</th><th>15 MONTHS</th><th>18 MONTHS</th><th>19-23 MONTHS</th><th>2-3 YEARS</th><th>4-6 YEARS</th></tr>
<tr><td>HepB Hepatitis B</td><td>HepB</td><td colspan="2">HepB</td><td></td><td colspan="4">HepB</td><td></td><td></td><td></td></tr>
<tr><td>RV Rotovirus</td><td></td><td></td><td>RV</td><td>RV</td><td>RV</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>DTaP Diptheria, tetanus, & acellular pertussis</td><td></td><td></td><td>DTaP</td><td>DTaP</td><td>DTaP</td><td></td><td colspan="2">DTaP</td><td></td><td></td><td>DTaP</td></tr>
<tr><td>Hib Haemophilus influenzae type b</td><td></td><td></td><td>Hib</td><td>Hib</td><td>Hib</td><td colspan="2">Hib</td><td></td><td></td><td></td><td></td></tr>
<tr><td>PCV15, PCV20 Pneumococcal conjugate</td><td></td><td></td><td>(PCV15, PCV20)</td><td>(PCV15, PCV20)</td><td>(PCV15, PCV20)</td><td colspan="2">(PCV15, PCV20)</td><td></td><td></td><td></td><td></td></tr>
<tr><td>IPV: <18 yrs) Inactivated poliovirus</td><td></td><td></td><td>IPV</td><td>IPV</td><td colspan="4">IPV</td><td></td><td></td><td>IPV</td></tr>
<tr><td>Influenza</td><td></td><td></td><td></td><td></td><td colspan="7">Influenza (Yearly)*</td></tr>
<tr><td>MMR</td><td></td><td></td><td></td><td></td><td></td><td colspan="2">MMR</td><td></td><td></td><td></td><td>MMR</td></tr>
<tr><td>Varicella</td><td></td><td></td><td></td><td></td><td></td><td colspan="2">Varicella</td><td></td><td></td><td></td><td>Varicella</td></tr>
<tr><td>HepA§</td><td></td><td></td><td></td><td></td><td></td><td colspan="4">HepA§</td><td></td><td></td></tr>
</table>

Note: If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

Footnotes

[*]Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

[§]Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the first dose. All children and adolescents over 24 months of age who have not been vaccinated should also receive 2 doses of HepA vaccine.

VACCINE	7-10 YEARS	11-12 YEARS	13-15 YEARS	16 YEARS	17-18 YEARS
HepB Hepatitis B					
RV Rotovirus					
DTaP Diptheria, tetanus, & acellular pertussis					
Hib Haemophilus influenzae type b					
PCV13					
IPV					
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)	1 or more doses of updated (2023–2024 Formula) vaccine				
Influenza	Annual vaccination				
MMR Measles, mumps, rubella					
VAR Varicella					
HepA§					
Tdap Tetanus, diptheria, & acellular pertussis		Tdap			
HPV Human Papillomavirus		HPV			
Meningococcal		**Meningococcal**		**Meningococcal**	

Immunization schedules can also be found on the Centers for Disease Control and Prevention (CDC) website: **https://www.cdc.gov/vaccines/schedules/**

Wellness care for adults

Staying healthy means seeing your PCP regularly for checkups. Use this chart to make sure you are up to date with your yearly wellness exams.

Wellness visits schedule for adult members

Exam type	Who needs it?	How often?
Wellness visit	Men and women ages 21–49 years Men and women ages 50 years+	Every 2–3 years Yearly

Hypertension (high blood pressure) screening	Men and women ages 21 years+	Yearly or as your doctor suggests
Colonoscopy (colon cancer screening)	Men and women ages 45 years+	Beginning at age 45 and then every 10 years
Mammogram (breast cancer screening)	Women ages 40 years+	Each year from ages 40–65+ Consider screening every 2 years from ages 50–74*
PAP test (cervical cancer screening) and pelvic exam	Women ages 21–29 years Women ages 30–65 years	Every 3 years Either Pap test every 3 years or human papillomavirus (HPV) test alone, or combined Pap and HPV every 5 years
Prostate-specific antigen (PSA) test (prostate cancer screening)	Men age 55 years+**	From ages 55–69, talk with your doctor about risks and benefits of prostate cancer testing

** Talk to your doctor about the best age to start having mammograms and possibly screen every two years when older.*
*** 40 years and older yearly if family history of prostate cancer.*

SPECIAL KINDS OF HEALTHCARE

Eye care

Anthem members do not need a referral from their PCPs for eye care benefits. Members can receive:

- One complete eye exam every 12 months.
- Refractive exams.
- Fittings, dispensing, and adjustment of glasses.
- Frames and lenses.
- Follow-up exams.
- Contact lenses (in certain circumstances).

Members ages 20 and under receive eyeglasses as often as medically needed* (or for broken or lost glasses) as part of the Healthchek program.

* Medically needed is when an eye exam shows a significant change in vision.

See **Ophthalmology/Optometry Services** under the section **Anthem covered services** for more details. If you need help finding a plan eye doctor (optometrist) in your area, call EyeMed Vision Care toll-free at **877-658-1801 (TTY 711)**.

Behavioral health (mental health/substance abuse)

Behavioral health services
Mental health and substance use disorder treatment services are available. These services include:

- Diagnostic evaluation and assessment
- Psychological testing

- Psychotherapy and counseling
- Crisis intervention
- Mental health services including therapeutic behavioral service, psychosocial rehabilitation, community psychiatric supportive treatment, assertive community 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
- Medication-assisted treatment for addiction
- Opioid treatment program services
- Medical services
- Behavioral health nursing services
- Mobile Response and Stabilization Service (MRSS)

Mental health and/or substance use disorder treatment services

Sometimes, dealing with all of the tasks of a home and family can lead to stress. Stress can lead to depression and anxiety. It can also lead to problems with marriage, family, and parenting. Stress can lead to alcohol and drug abuse, too.

If you or a family member are having these kinds of problems, you can receive help. Call Anthem Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time. You can also be given the name of a behavioral health specialist who will see you if you need one.

Your benefits include many medically needed services, such as:

- Inpatient mental healthcare
- Outpatient mental healthcare (counseling/therapy)
- Behavior modification (Applied Behavioral Analysis)
- Psychiatric services/medication management
- Crisis services
- Alcohol and substance use disorder treatment, including intensive outpatient treatment.
- Case management services
- Mental health rehabilitative treatment services

You do not need a referral from your PCP to receive these services or to see a behavioral health specialist in your network.

If you think a behavioral health specialist does not meet your needs, talk to your PCP. They can help you find a different kind of specialist.

There are some treatments and services your PCP or behavioral health specialist must ask Anthem to approve before you can receive them. Your doctor will be able to tell you what they are.

If you have questions about referrals and when you need one, contact Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

OhioRISE

OhioRISE (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 addition, 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-services (FFS) Medicaid.

OhioRISE Eligibility

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

• Are eligible 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 Assessment

To have a child or youth assessed for OhioRISE, contact Anthem BCBS Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time. 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 Anthem BCBS Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time or Aetna OhioRISE Member Services at 833-711-0773 (TTY 711).

Applied behavioral analysis

Anthem has a benefit to help families with children 21 years and younger touched by autism spectrum disorder. This benefit is called applied behavioral analysis or ABA. When a child is diagnosed with autism spectrum disorder (ASD), families need as much support as possible. The Behavioral Health team can help you find a provider certified in ABA services and determine if ABA is suitable for your child. They will also help you and your family with other referrals in order to offer you well-rounded support.

We offer you and your family Utilization Management and Case Management services from licensed behavioral health clinicians, which includes:

- Authorization and review of ABA services
- Connecting your family with community resources
- Providing on-going support and answering your questions about coverage, authorizations and providers, as well as assisting all members of the family
- Helping you fit your new support systems into daily life

- Our Behavioral Health team can guide your family through this process. They will coordinate care and help you understand the healthcare system. Our goal is to help families make good use of their benefits. To learn more about the ABA benefit, call the Behavioral Health team at **844-396-2331 (TTY 711)**.

Coordinated Service Program

The availability and access to controlled medications and opioids used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address this growing epidemic, Anthem has implemented the Coordinated Service Program to allow for better administration of drug benefits through increased communication and coordination amongst doctors and pharmacies.

This program helps reduce potential overutilization of prescription medications by identifying individuals who may benefit from oversight by managing their access to controlled medications through assigned providers such as a pharmacy or primary care provider. Identification for enrollment into the program is determined by the retrospective utilization of healthcare services including the member's prescription claims history. If a member is believed to be at an increased safety risk due to the utilization of multiple medications, providers and/or pharmacies, and meets enrollment criteria, they may be included in this program.

Anthem is more committed than ever to equipping providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments regarding enrollment, please contact the Member Services number located on the back of the covered member's ID card.

Family planning services

Anthem will arrange for counseling and education about planning a pregnancy. By talking to your PCP, you can learn about preventing pregnancy. You can also visit any family planning provider, even if the provider is not part of the Anthem network. You do not need a referral from your PCP.

Medications

Prescription drugs

Your pharmacy benefits are covered under the state Medicaid program and managed by Gainwell Technologies. If you have questions about your pharmacy benefits, call **833-491-0344 (TTY 833-655-2437)** or visit **spbm.medicaid.ohio.gov**. You can also visit the **Pharmacy Benefits** page on the member website, **anthem.com/oh/medicaid,** or see attached Appendix A-Ohio Single Pharmacy Benefit Manager (SPBM) to view the pharmacy handbook, the list of drugs covered under your pharmacy benefit (Preferred Drug List), and the provider directory.

Anthem members will use Gainwell to process prescription claims and will need to refer to the Gainwell member handbook for assistance.

Gainwell has a list of prescription medicines included on the Preferred Drug List, or PDL. The PDL is a

list of medicines that Gainwell covers. There are brand name medicines and generic medicines on the Preferred Drug List. You can get many of these medicines at your pharmacy with a prescription from your doctor. But some of these medicines must have an OK from the Gainwell pharmacy program before you can get them. This OK is called a prior authorization, or PA. Your doctor must ask for a PA for some of the medicines on the list. Sometimes your doctor can change your prescription to a medicine that doesn't need a PA. But if your doctor says you must have medicine that needs an OK, he or she must ask for a Prior Authorization .

If you have a complex or chronic condition and need specialty medications, CarelonRx Specialty Pharmacy is our preferred vendor to fill them. These medications are delivered to you at home or shipped to a local CVS Pharmacy for pickup at no cost to you. To find a specialty pharmacy near you, use the pharmacy locator tool on the member website. With CarelonRx, you can use your online account to refill prescriptions, set up home delivery, and check order status.

Physician administered medical injectable

Some injectable medications may be given in your doctor's office. These are not injections that you can give to yourself. For this type of medication, your doctor can call us for help with which medications are covered under your medical benefit. Some of these medications may also need an OK from us before you get them.

Special care for pregnant members

New Baby, New Life℠ is the Anthem program for all pregnant members. It is very important to see your primary care provider (PCP) or obstetric (OB) care provider for care when you are pregnant. This kind of care is called **prenatal care**. It can help you to have a healthy baby. It is important that you seek prenatal care each time you are pregnant. With our program, you have access to health information and may receive incentives for going to your appointments.

Our program also helps pregnant members with complicated healthcare needs. Nurse care managers work closely with these members with high risk pregnancies to provide:

- Prenatal and postpartum education
- Emotional support
- Help in following their OB care provider's care plan
- Information on services and resources in your community

Our nurses also work with OB care providers and help with other services you may need. The goal is to promote better health for members and delivery of healthy babies.

Quality care for you and your baby

At Anthem, we want to give you the very best care during your pregnancy. That's why you also have access to a digital maternity program which is offered at no cost as part of our New Baby, New Life

program. The digital maternity program gives you the information and support you need to stay healthy during your pregnancy and after you deliver.

Get to know our Digital Maternity Program

The digital maternity program delivers maternal health education by smartphone app, that is helpful and fun. You can count on:

- Prenatal and postpartum education you can use
- Communication with the care management team via chat.
- Information delivery on a time schedule that works for you.
- No cost to you

Helping you and your baby stay healthy

The Anthem digital maternity program can give you answers to your questions, plus clinical support, if you need it. There is an important pregnancy screener that you'll complete shortly after you download the app and register, followed by ongoing educational outreach and fun activities via the smartphone app. All you need to do is download the app to learn, have fun, and answer a few questions. You can also chat with the case management team if a question comes up that isn't answered in the app.

When you become pregnant

If you think you are pregnant

- Call your PCP or OB care provider right away. You do not need a referral from your PCP to see an OB care provider.
- Call Member Services if you need help finding an OB care provider.
- Visit the Anthem pregnancy website at https://www.anthem.com/oh/medicaid/health-topics/pregnancy-and-womens-health to check out resources and education and learn how to access the digital maternity program.

When you become pregnant

When you find out you are pregnant, you must also call Member Services. You should also report your pregnancy to Ohio Department of Medicaid at 800-324-8680 (TTY 800-292-3572).

Visit our Pregnancy and Wellness page at https://www.anthem.com/oh/medicaid/health-topics/pregnancy-and-womens-health for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Member Services at the number on your member ID card.

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from Women, Infants and Children program (WIC). You can learn more about WIC and find a location close to you online at https://www.fns.usda.gov/wic.

When you are pregnant, you must go to your PCP or OB care provider at least:

- Every four weeks for the first six months
- Every two weeks for the seventh and eight months
- Every week during the last month

Your PCP or OB care provider may want you to visit more than this based on your health needs.

When you have your baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 72 hours after a cesarean section (C-section)

You may stay in the hospital less time if your PCP or OB care provider, and the baby's provider, sees that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB care provider may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby, you must:

- Call Member Services as soon as you can to let us know you had your baby. We will need details about your baby.
- Call your Ohio Department of Medicaid at 800-324-8680 (TTY 800-292-3572) to apply for Medicaid for your baby.

After you have your baby

After your baby is born, the digital maternity program will provide you access to postpartum education as well as valuable education about your baby.

It's important to set up a visit with your PCP or OB care provider after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- The visit should be done between 7 to 84 days after you deliver
- If you delivered by C-section or had complications with your pregnancy or delivery, your PCP or OB care provider may ask you to come back for a one- or two-week checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 7 to 84 days after your delivery for your postpartum checkup.

Anthem may cover the cost of a breast pump. Contact Member Services to learn about how you can get a breast pump.

You can learn more about the New Baby, New Life program and our digital maternity program online at https://www.anthem.com/oh/medicaid/health-topics/pregnancy-and-womens-health or by calling Member Services and asking to speak to an OB care manager.

CARE MANAGEMENT SERVICES

Anthem offers care management services. The Anthem Care Management program provides you with information on how to stay healthy and live your best life. **Care Management services are provided whether you are well, have an ongoing health problem, or have a terrible health episode**. As part of your Anthem benefits, we're here to help you learn more about your health, keeping you and your needs in mind at every step.

If you have an ongoing illness or an unhealthy behavior, Care Management services can help you do things like:

- Understand your illness and how to feel better
- Quit smoking
- Manage your weight
- Have a healthy pregnancy and healthy baby
- Help you navigate the health system and coordinate care among multiple providers

Care Management programs are available to you depending on your health risks . You may also request care management and care coordination services direct from Anthem.

Anthem can provide you with a care manager who can help you get all the care you need. You may be able to have a care manager if you:

- Go to the ER a lot, or if you have to go into the hospital a lot.
- Need healthcare before or after you have a transplant.
- Have a lot of different doctors for different health problems.
- Have an ongoing illness that you don't know how to deal with.

To request a care manager, or if you want to participate in Care Management, you or your provider, or someone on your behalf can call Anthem Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time.

Our team includes registered nurses or licensed mental health clinicians called care managers. They will help you learn how to better manage your condition or health issue. There are also care guides to support you when receiving care and services from multiple agencies. You can choose to join a Care Management program for free.

What programs do we offer?
You can join a Care Management program to receive support services for a variety of healthcare needs and conditions including Disease Management. Disease Management, a type of care management program, may be able to assist if you have any of these conditions:

Asthma	HIV/AIDS
Bipolar disorder	Hypertension
Chronic obstructive pulmonary disease (COPD)	Major depressive disorder – adult
Congestive heart failure (CHF)	Major depressive disorder – child and adolescent
Coronary artery disease (CAD)	Schizophrenia
Diabetes	Substance use disorder

How it works
When you join one of our Care Management programs, a care manager will:

- Help you create health goals and make a plan to reach them.
- Coach you and support you through one-on-one phone calls and/or face-to-face visits.
- Track your progress.
- Give you information about local support and caregivers.
- Answer questions about your condition and/or treatment plan (ways to help health issues).
- Send you materials to learn about your condition and overall health and wellness.
- Coordinate your care with your healthcare providers, like helping you with:
    - Making appointments.
    - Finding ways to visit your healthcare provider.
    - Referring you to specialists in our health plan, if needed.
    - Receiving medical equipment you may need.
- Offer educational materials and tools for weight management and tobacco cessation (how to stop using tobacco — like quitting smoking).

Our care management team and your primary care provider (PCP) are here to help you with your healthcare needs.

How to join
One of our Care Management teams may call or text you or send you a letter if eligible for one of our programs. You can also call us toll free at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time to request care management services.

When you call, we'll:

- Set you up with a care manager.
- Ask you some questions about you or your child's health.
- Start working together to create your or your child's plan.

For members with the conditions listed above wishing to talk to a case manager in Disease Management, you can call us at **888-830-4300 (TTY 711)** or you can also email us at dmself-referral@anthem.com. Please be aware that emails sent over the internet are usually safe, but there is some risk that third parties

may access these emails without you knowing. By sending your information in an email, you acknowledge (or know, understand) third parties may access these emails without you knowing.

You can choose to opt out of any care management program (we'll take you out of the program) at any time. Please call your care manager directly or call Member Services toll-free at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time and let the representative know you would like to opt out.

Useful phone numbers

In an emergency, call **911**.

Member Services
Toll-free **844-912-0938 (TTY 711)**
Monday through Friday
7 a.m. to 8 p.m. Eastern time

Disease Management
Toll-free **888-830-4300 (TTY 711)**
Monday through Friday
8:30 a.m. to 5:30 p.m. local time
Leave a private message for your case manager 24 hours a day.

After-hours:
Call 24/7 NurseLine
24 hours a day, seven days a week
844-430-0341 (TTY 711)

Care Management rights and responsibilities
When you join a care management program, you have certain rights and responsibilities. You have the right to:

- Receive details about us, such as:
  - Programs and services we offer.
  - Our staff and their qualifications (skills or education).
  - Any contractual relationships (deals we have with other companies).
- Opt out of care management services.
- Know which care manager is handling your services, and how to ask for a change.
- Receive support from us to make healthcare choices with your healthcare providers.
- Ask about all care management-related treatment options (choices of ways to feel better) mentioned in clinical guidelines (even if a treatment is not part of your health plan) and talk about options with treating healthcare providers.

- Have personal date and medical information kept private.
- Know who has access to your information and how we make sure your information stays secure, private, and confidential.
- Receive polite, respectful treatment from our staff.
- Receive information that is clear and easy to understand.
- File complaints to Anthem by calling toll-free **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time and:
    - Receive help on how to use the complaint process.
    - Know how much time Anthem has to respond to — and resolve issues of — quality and complaints.
    - Give us feedback about the care management program.

You also have the responsibility to:

- Follow the care plan that you and your care manager agree on.
- Give us information needed to carry out our services.
- Tell us and your healthcare providers if you choose to opt-out (leave the program).

Care Management does not market products or services from outside companies to our members. Care Management does not own or profit from outside companies on the goods and services we offer.

SPECIAL ANTHEM SERVICES FOR HEALTHY LIVING

Health information

Learning more about health and healthy living can help you stay healthy. Here are some ways to receive health information:

- Ask your primary care provider (PCP).

Call us. 24/7 NurseLine is available 24 hours a day, seven days a week to answer your questions. They can tell you:

- If you need to see your PCP.
- How you can help take care of some health problems you may have.

Health A to Z

Anthem wants to help you make better health choices with Health A to Z. This is an online resource that is easy to use and includes a symptom checker, tests, tools, and information on many health topics. Health A to Z is your one-stop for questions about your health. Access Health A to Z on our website at **anthem.com/oh/medicaid** and choose *Programs and Info in Your Community*.

Health resources

Anthem can help you find health resources near your home. You can call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time or go online at **anthem.com/oh/medicaid** to find out where and when these programs are held.

Some of the programs include:

- Childbirth
- Infant care
- Parenting
- Pregnancy
- Quitting cigarette smoking
- Protecting yourself from violence
- Other programs about health topics

Anthem will also mail you member newsletters that will provide information about well care and taking care of illnesses.

Anthem sponsors and participates in community events and family-fun days where you can receive health information and have a good time. Call Member Services or go online at **anthem.com/oh/medicaid** to find out when and where these events will be.

Domestic violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hit you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect your children, and it can affect you. If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. He or she can help you understand you have done nothing wrong and don't deserve abuse.

Safety tips for your protection:

- If you are hurt, call your PCP.
- Call **911** or go to the nearest hospital if you need emergency care. Please see the section **Emergency Care** for more information.
- Have a plan on how you can make it to a safe place (like a women's shelter or a friend's or relative's home).
- Pack a small bag and give it to a friend to keep until you need it.

If you have questions or need help:

- Call 24/7 NurseLine at **844-430-0341 (TTY 711)**.
- Call the National Domestic Violence hotline number at **800-799-7233 (TTY 711)**.

MINORS

Our network doctors and hospitals cannot give care to most Anthem members under age 18 without a parent's or legal guardian's consent. This does not apply if emergency care is needed.

Parents or legal guardians also have the right to know what's in their child's medical records. Members under age 18 can ask their PCP not to tell their parents about their medical records, but the parents can still ask the PCP to see the medical records.

These rules do not apply to emancipated minors. Emancipated minors may make their own decisions about their medical care and the medical care of their children. Parents no longer have the right to see the medical records of emancipated minors.

Members under age 18 may be emancipated minors if they:

- Are married.
- Are pregnant.
- Have a child.
- Are emancipated by court order.

ADVANCE DIRECTIVES (LIVING WILLS OR DURABLE POWERS OF ATTORNEY)

Emancipated minors and members over 18 years old have rights under the state's advance directive law. An advance directive is a written statement by you, telling how you want medical decisions made if you become unable to decide for yourself. There are a few types of advance directives:

1. **Living will or declaration** — a living will tell your healthcare providers and family about the type of life-sustaining actions you want, and do not want, if you suffer from a terminal illness or an irreversible condition. A living will does not apply unless you cannot make decisions for yourself; until then, you'll be able to say what treatments you want or don't want.
2. **Durable power of attorney for healthcare** — a durable power of attorney for healthcare will let you pick a person to make decisions for you when you can't make them yourself. You can also include information about any treatment you want or do not want. Ask your PCP or specialist about these forms.

You can have either a living will or a durable power of attorney for health, or you can have both documents. A living will is your personal statement regarding the types of life-sustaining treatment you want if you are not able to share your desires. A durable power of attorney for healthcare covers more than the living will. It covers any medical decisions, not just decisions concerning life-sustaining treatment.

If you wish to sign a living will, you can:

- Ask your PCP for a living will form or call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time to receive one.
  - Fill out the form.
  - Take or mail the completed form to your PCP or specialist; your PCP or specialist will then know what kind of care you want to receive.

You can change your mind any time after you have signed a living will:

- Call your PCP or specialist to remove the living will from your medical record.
- Fill out and sign a new form if you wish to make changes in your living will.

Your PCP will require you to sign the Acknowledgement of Patient Information on Advance Directives form. Your signed form, along with your advance directive, will be kept on file with your medical record.

Right to make decisions

You have the right under state law to make decisions concerning your medical and/or your behavioral healthcare, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Individual and institutional objection

An individual objection is when your individual PCP or other providers treating you will not honor your advance directive on the basis of their conscience (beliefs).

An institutional objection is when an entire institution, like a hospital or health system, will not honor your advance directive for reasons of conscience (beliefs). The range of medical conditions that may be objected to by individual and institutional providers could be different from provider to provider. Be sure to ask your PCP and other providers if they have objections to the requests you have included in your advance directive.

If your PCP or other provider objects to the request for care you make in your advance directive, you have the right to select another PCP or provider who will honor your request. Please call Member Services at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help.

If you have a grievance about your advance directive, contact Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time or file your grievance with DHCFP at:

Anthem Blue Cross and Blue Shield
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 888-235-9334

GRIEVANCES AND MEDICAL APPEALS

Appeals and grievances

If you are unhappy with Anthem 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 let us know. Anthem wants to help.

To contact us, you can:

1. Contact Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time.
2. Fill out the form in your member handbook found in Appendix A.
3. Log on to the member portal at **anthem.com/oh/medicaid** and look for the appeal form.

4. Use the mobile application Sydney to find the appeal form.
5. Write a letter telling us what you are unhappy about. Please include your first and last name, the number from the front of your Anthem member ID card, your address, and your telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

Anthem Blue Cross and Blue Shield
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 888-235-9334

Anthem will send you something in writing if we decide 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.
- Deny payment for a service you received that is not covered by Anthem.

We will also send you something in writing if we did not:

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

If you have any questions or concerns about your Anthem benefits, please call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time. You can also write to us at:

Anthem Blue Cross and Blue Shield
P.O. Box 62429
Virginia Beach, VA 23466-2429
Fax: 888-235-9334

If you have difficulty understanding English and need to file an appeal or complaint in your primary language, you can request a bilingual staff member or an interpreter who can explain this information in your primary language, at no cost to you.

If you have difficulty hearing or seeing, or have other needs, you can request at no cost to you, information in different formats such as large print, Audio, Braille, and other. Please call our Member Services toll-free at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time for help.

Grievances

If you contact us because you are unhappy with Anthem or Anthem's decision, or our providers, this is called a grievance. Anthem 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:

- Anthem will acknowledge receipt of each grievance to the member filing the grievance. If the grievance is filed in writing, written acknowledgment will be made within three business days of receipt of the grievance.
  - Two working days for grievances about not being able to get medical care
  - 30 calendar days for all other grievances except grievances about getting a bill for care you have received
  - 60 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 to file a complaint at any time by contacting the:

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

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

Appeals

If you do not agree with the decision or action listed in the letter, you can 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. If we have decided 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.

Unless we tell you a different date, we must 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 because 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 Anthem appeal process.**

Medical appeals

There may be times when Anthem says we will deny, end, or reduce a service we approved. We may also say we will not pay for all or part of the care your provider asked for. If we decide to deny the care a provider asked for, or to end or reduce a service you are currently approved to receive, we will send you a letter called a Notice of Action.

For standard approval requests, Anthem has10 calendar days to respond and either approve or deny the service request.

For expedited (rushed) approval requests, when you need a quick response, Anthem has 48 hours or less to respond and either approve or deny the service request. If Anthem is reducing or ending a previously authorized service, we must send you a Notice of Adverse Benefit Determination at least 15 days before the date we plan to reduce or end the covered service.

If Anthem sends you a Notice of Adverse Benefit Determination, you can appeal the decision. Your provider can appeal our decision for you if he or she has your written permission.

A medical appeal is when you ask us to look again at the care we said we would not pay for. You must file for a medical appeal within 60 calendar days from the date on the Notice of Adverse Benefit Determination letter. A medical appeal can be filed by:

- You.
- A person helping you.
- Your provider taking care of you at the time.

If you want your provider to file an appeal for you, he or she must have your written permission.

To continue receiving services we have already approved and are now denying, you or your provider can complete an Appeal or Fair Hearing on or before the later of:

- 15 calendar days after we mail the denial notice.
- The date the notice says your service will end.

You can appeal our decision in several ways:

- Log on to the member portal at **anthem.com/oh/medicaid** and look for the appeal form.
- Use the mobile application Sydney to find the appeal form.

Call us

- Call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. Eastern time and ask to appeal.
- Let us know if you want someone else to help you with the appeal process, such as a family member, friend, or the provider taking care of you at the time.

Write us

- Send us an appeal form attached to your letter.
- Have your doctor send us your medical information about this service to:

  Medical Appeals
  Anthem Blue Cross and Blue Shield
  P.O. Box 62429
  Virginia Beach, VA 23466-2429

After we receive your appeal:

- We will send you a letter within three business days from when we receive your request.
- A different provider than the one who made the first decision will look at your appeal.
- We will send you and your provider a letter telling you about our decision within 15 calendar days from when we receive your appeal or within 72 hours if you asked for an expedited appeal. See the section called Expedited Appeals or details.

We will tell you and your provider how to find out more about the decision. We will tell you your rights to request a state fair hearing if you aren't happy with our decision. You may also request a copy (free of charge) of the documents used to make the appeal decision, including your medical records, actual benefit provision, guideline, protocol, or criteria we based our decision on.

If we need more information about your appeal:

- We may ask for medical records to help us make a decision. You, or your provider giving you care, must forward the records to us. Upon state approval or your request, we may extend the appeal process up to 14 calendar days if it is in your best interest.
- If the state approves our extension request, we will let you — or the person you asked to file the appeal for you — know in writing within two calendar days the reason for the delay. If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

You may ask us to extend the process if you know more information that we should consider.

After you have completed the Anthem appeal process, you may ask for a state fair hearing. See the section **Fair Hearings** for more details.

Expedited appeals

You or the person you ask to file an appeal for you can request an expedited appeal. You can request an expedited appeal if you or your provider feels that taking the time for the standard appeals process could seriously harm your life or your health.

You or your provider can request an expedited appeal. Call Member Services toll-free at **844-912-0938 (TTY 711)**, Monday through Friday from 7 a.m. to 8 p.m. Eastern time When we receive your call, we will send you a letter with our decision within 72 hours.

If you have more information you'd like us to look at, you must give it to us right away. If we need more information about your appeal:

- Upon state approval, we may extend the appeals process up to 14 calendar days.
- If the state approves our extension request, we will let you know in writing the reason for the delay. If you are not happy with the extra time we need to complete the review, you can file a grievance about the delay.

You may also ask us to extend the process if you have more details that we should review.

If we don't agree that your request for an appeal should be expedited, we'll:

- Call you right away.
- Send you a letter within two calendar days to let you know how the decision was made, and that your appeal will be reviewed through the standard review process of 15 calendar days.

If the decision on your expedited appeal upholds (agrees with) our first decision and we will not pay for the care your doctor asked for, we will call you and send you a letter. This letter will:

- Let you know how the decision was made.
- Tell you about your rights to request an expedited state fair hearing.

Provider payment appeals

If you receive a service from a provider and we do not pay for that service, you may receive a notice from Anthem called an Explanation of Benefits (EOB). **This isn't a bill.** The EOB will tell you:

- The date you received the service.
- The type of service.
- The reason we can't pay for the service.

If you receive an EOB, you don't need to call or do anything at that time, unless you want to appeal the decision.

A payment appeal is when your provider asks Anthem to look again at the service we said we would not pay for. Your provider must ask for a payment appeal within 60 calendar days of receiving the EOB.

Payment appeals must be submitted in writing by your provider.

Fair hearings

State hearings

A state hearing is a meeting with you or someone you want to speak on your behalf, someone from the County Department of Job and Family Services, someone from Anthem, 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 Anthem did not make the right decision and Anthem 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.

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

- We do not change our decision or action because of your appeal.
- A decision is made to propose enrollment or continue enrollment in the Coordinated Services Program.
- A decision is made to deny your request to change your Coordinated Services Program provider.

You may only request a state hearing after you have gone through Anthem's appeal process.

If you want a state hearing, you, or someone you want to speak on your behalf, must request a hearing **within 90 calendar days.** The 90 calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before all 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 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.

To request a state 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 **866-635-3748**
- Submit your request online at **https://hearings.jfs.ohio.gov/apps/SHARE/#_frmLogin**
- Submit your request via e-mail at bsh@jfs.ohio.gov

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at **800-589-5888**.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if MCO or the Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed but no later than three 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, your health or your ability to attain, maintain, or regain maximum function.

Anthem will pay for services you receive during the time your benefits were continued until a final decision is made. **You may have to pay for the cost of any continued benefit if the final decision isn't in your favor.**

If a decision is made in your favor as a result of your Appeal or Fair Hearing, we will authorize and pay for the services we denied coverage of before as expeditiously as possible but no later than 72 hours from the date we are notified of the decision.

OTHER INFORMATION

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**.

If you move or your family size changes

If you are a Medicaid member, you must contact your County Department of Job and Family Services (DJFS) caseworker as soon as you move to report your new address or if your family size changes. Once you call the state, you should then call Anthem Member Services at **844-912-0938 (TTY 711)**. If you move out of the service area, you will continue to receive healthcare services through us until you are disenrolled. You must call Anthem before you can receive any services in your new area unless it is an emergency.

How to renew your Medicaid benefits on time

Keep the right care. You need to renew your benefits every 12 months. If you do not, you could lose your Medicaid benefits, even if you still qualify.

If you are an Ohio Medicaid member, the Ohio Department of Medicaid (ODM) will send you a letter telling you it is time to renew your Medicaid benefits. You will receive a renewal package about two months before the date you need to renew your benefits. You can return the packet via mail or renew online at **benefits.ohio.gov**.

If you do not renew your eligibility by the date in the letter, you will lose your healthcare benefits. Your DJFS caseworker can answer your questions about renewing your benefits. We want you to keep receiving your healthcare benefits from us as long as you still qualify. Your health is very important to us.

If you are no longer eligible for Medicaid

You will be disenrolled from Anthem if you are no longer eligible for Medicaid.

Automatic renewal of MCO membership
If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become an Anthem member again. If possible, you will be given the same PCP you had when you were with Anthem before. You will be assigned to the same PCP as your other family members where appropriate.

Other health insurance (coordination of benefits, COB)
If you or anyone in your family has health insurance with another company, it is <u>very important</u> that you call Member Services 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, you need to call Member Services. It is also important to tell Member Services and your county caseworker if you have lost health insurance that you previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills.

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

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

How to disenroll from Anthem

Ending your Anthem membership
As a member of a managed care organization (MCO), 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. The Ohio Department of Medicaid will send you something in the mail to tell you when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care organization to cover your healthcare services.

If you want to end your membership during the first three months of your membership or during the annual open enrollment month, you can call the Medicaid Hotline at **800-324-8680 (TTY 800-292-3572)**. You can also submit a request online to the Medicaid Hotline website at www.ohiomh.com. 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 organization, your new managed care organization will send you information in the mail before your membership start date.

Choosing a new plan
If you are thinking about ending your membership to change to another managed care organization (MCO), you should learn about your choices. Especially if you want to keep your current provider(s). Remember, each MCO has its own list of doctors and hospitals that are in the network. Each MCO also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care organization you are thinking of joining or if you simply have questions about the MCO, you may either call the plan or call the Medicaid Hotline at **800-324-8680 (TTY 800-292-3572)**. You can also find information about the MCOs in your area by visiting the Medicaid Hotline website at www.ohiomh.com.

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. To ask for a just cause membership termination, you may first call Anthem and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination if you have one of the following reasons:

1.You move and your current MCO is not available where you now live, and you need non-emergency medical care in your new area before your MCO membership ends.

2.Your current MCO 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 the services are not all in the MCO's network.

4.You have concerns that you are not receiving quality care and the services you need are not available from another provider in the Anthem network.

5.You do not have access to medically necessary Medicaid-covered services or do not have access to providers that are experienced in dealing with your special healthcare needs.

6.The PCP that you chose is no longer on your in the Anthem network and that was the only in-network PCP who spoke your language and was located within a reasonable distance from you; or another plan has a PCP in their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.

7. 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 end your membership for just cause by calling the Medicaid Hotline at **800-324-8680 (TTY 800-292-3572)**. The Ohio Department of Medicaid will review your request and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date your membership ends. If you live in a mandatory enrollment area, you will have to choose another plan unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership
If you have followed any of the above steps to end your membership, remember:

- Continue to use Anthem doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- 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 Anthem Member Services. If they are unable to help you, call the Medicaid Hotline at **800-324-8680 (TTY 800 292-3572)**.
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.

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

Optional membership terminations

You have the option not to be a member of a managed care organization (MCO) 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 organization, you can call the Medicaid Hotline at **800-324-8680 (TTY 800-292-3572)**. If you meet the above criteria and does not want to be an MCO member, your MCO membership will be ended.

Exclusions — Individuals that are not permitted to join a Medicaid MCO

You may not be allowed to join a Medicaid managed care organization (MCO) if you are:

- 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, intermediate care facility for individuals with intellectual disabilities (ICF/IID), 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 Organization. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Organization.

If you believe that you meet any of the above criteria and should not be a member of a Managed Care Organization, you must call the Medicaid Hotline at **800-324-8680 (TTY 800-292-3572)**. If you meet the above criteria, your MCO membership will be ended.

Can Anthem end my membership?

Anthem 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.

Reasons you can be disenrolled from Anthem

The reasons Anthem can ask to end your membership are:

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

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

Ohio Department of Medicaid
Office of Managed Care
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, OH 43218-2709

Phone: 800-324-8680
TTY 800-292-3572
You can also visit the Ohio Department of Medicaid on the web at **medicaid.ohio.gov**.

You can contact Anthem to get any other information you want including the structure and operation of Anthem and how we pay our providers. If you want to tell us about things you think we should change, call Member Services at **844-912-0938 (TTY 711)**.

Reasons you cannot be disenrolled from Anthem

Anthem may not request you be disenrolled for any of the following reasons:

- Your health status changes.
- You have pre-existing medical conditions.
- Your mental ability decreases.
- You use medical services.
- You have special needs that do not affect your ability to receive medical services.
- You file a grievance or appeal.
- Your age, national origin, creed, color, sex, or religion.

If you receive a bill or your primary care provider charges you a fee

When going to a provider, always verify that he or she is in the Anthem network. Always show your Anthem ID card when you visit a provider, go for tests or to the hospital. Showing your member ID card tells the provider to bill the covered medical services to Anthem.

Under the Ohio Medicaid program, your PCP cannot bill you or charge you a fee for any of the following:

- You cancel or do not go to your appointment.
  - If you refuse to sign a form saying you will pay for missed appointments, your provider is not allowed to withhold treatment or refuse to let you return.
- You ask for the first copy of your medical records.
  - You will be charged a reasonable fee for extra copies.
- Your PCP does not submit your claim for services to Anthem within a certain period of time.
- Your PCP's claim for services has been rejected by Anthem and your provider has not submitted a corrected claim within a certain period of time.

If you are charged for any of these reasons, please call Member Services to report the issue. Anthem will contact your PCP and notify them they are not allowed to send you a bill.

The provider may bill the member when the MCO (Anthem) denied prior authorization or referral for the services and the following conditions are met:

i. The provider notified the member of the financial liability in advance of service delivery;
ii. The notification, by the provider, was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and
iii. The notification is dated and signed by the member.

If you have other health insurance (coordination of benefits)

Please call your County Department of Job and Family Services (DJFS) caseworker and Anthem Member Services at **844-912-0938 (TTY 711)** if you or your children have other insurance. The other insurance plan needs to be billed for your healthcare services before Anthem can be billed. Anthem will work with the other insurance plan on payment for these services.

Changes in your Anthem coverage

Sometimes, Anthem may have to make changes in the way we work, our covered services, or our network providers and hospitals. We will mail you a letter when we make changes in the services we cover. Your PCP's office may move, close, or leave our network. If this happens, we will call or send you a letter to tell you about this.

We can also help you pick a new PCP. You can call Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8 p.m. if you have any questions.

How to tell Anthem about changes you think we should make

Members can choose to serve on the Consumer Advocacy Committee, which meets quarterly. This offers members a time to find out more about us, ask questions, and give us suggestions for improvement. If you would like to be part of this group, call Member Services at **844-912-0938 (TTY 711)**.

Each year, we send surveys to some members. The surveys ask questions about how you like Anthem. If we send you a survey, please fill it out and send it back. Our staff may also call to ask how you like Anthem. Please tell them what you think. Your ideas can help us make us better. We want to give you the quality care you deserve.

How Anthem measures the quality of your care

To help providers and health plan employees choose the best care for specific health issues, we have a process to create, change, and distribute nationally known Clinical Practice Guidelines (CPGs) and health service delivery standards to all our providers. Members can also request a copy of the guidelines by contacting Member Services or the Quality Management department.

CPGs are based on scientific evidence and focus on a broad range of healthcare, including:

- Preventive health (keeping you healthy)
- Maternity care to help ensure healthy moms and babies
- Diabetes
- Cardiac care
- Mental health
- Other conditions

Anthem measures how often you need care and the quality of care you receive through a set of standard performance measures related to these guidelines, including:

- Frequency of childhood wellness visits
- Childhood immunizations
- Lead screenings
- Mammograms and Pap smears
- Pregnancy care
- Diabetes screenings and tests

These measures are tracked with other health plans. These measures also give us the chance to help improve your health by:

- Providing educational tools to you and your PCP through newsletters and community events.
- Mailing reminder cards to you and your family members to help you receive routine preventive care and shots on time.

Why does Anthem measure quality of care?

These results tell us how healthy you are. Some of the measures have tests that show good health or the right types of care. Some tests tell us when we need to watch your health to keep you from being sick.

What does this mean to you?
Anthem wants to help you stay healthy. You are the most important decision maker when it comes to making healthcare choices. Anthem reviews the care and services available to you, what we have provided, and your feedback. This helps us learn how we can make our services better.

What can you do about your own health?
You can also help your PCP know what kind of care is right for you by following these important steps:

- Receive tests and healthcare services on time.
- Keep appointments for routine checkups to help keep you healthy.
- Read and follow the instructions on any reminders you receive from Anthem.

If you have a question about your health or the kind of care you might need, please call 24/7 NurseLine at **844-430-0341 (TTY 711)**. Nurses are available anytime, day or night.

How Anthem pays providers

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (Fee-For-Service). Or your provider may be paid a set fee each month — for each member — whether or not the member actually receives services (capitation). Your provider may also participate in the Anthem Provider Quality Incentive Program (PQIP).

These kinds of pay may include ways to earn more money. This kind of pay is based on different things, like how happy a member is with the care or quality of care. It is also based on how easy it is to find and receive care.

If you want more details about how our contracted providers or any other providers in our network are paid, please call the Anthem Member Services department or write to us at:

Anthem Blue Cross and Blue Shield
P.O. Box 62509
Virginia Beach, VA 23462

YOUR RIGHTS AND RESPONSIBILITIES AS AN <ANTHEM> MEMBER

Anthem wants you to know your rights and responsibilities**.** We will tell you about them when you enroll, every year, and 30 days before any changes are made.

As an Anthem member, you have the following rights:

- To receive all information and services that Anthem must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.

- To know which care manager is handling your services, and how to ask for a change.
- To participate with providers in making decisions relating to your healthcare.
- To be able to take part in decisions about your healthcare as long as the decisions are in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To recommend changes in policies and procedures, including Anthem's member rights and responsibilities policy.
- To say "yes" or "no" to having any information about you given out unless Anthem must by law.
- To say no to treatment or therapy. If you say no, the provider or Anthem must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing about Anthem or the care services it provides. See the **Grievances and Medical Appeals** section of this handbook to learn more.
- To get help free of charge from Anthem and its providers if you do not speak English or need help in understanding information.
- To get all written member information from the Anthem:
  - At no cost to you.
  - In the prevalent non-English languages of members in the Anthem: service area.
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- 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 their care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 66 to learn more about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP in the Anthem network at least monthly. Anthem must send you something in writing that says who the new PCP is and the date the change began.
- To be free to carry out your rights and know that Anthem, doctors, or the Ohio Department of Medicaid will not hold this against you.
- To know that Anthem must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider in the Anthem network for covered woman's health services.
- To get a second opinion from a qualified provider in the Anthem network. If a qualified provider is not able to see you, Anthem must set up a visit with a provider not in our network.
- To get information about Anthem from us.
- To get information about Anthem services, doctors, and member rights and responsibilities
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of

discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status, or need for health services.

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709

Email: ODM_EmployeeRelations@medicaid.ohio.gov
Fax: 614-644-1434

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

Your responsibilities

As an Anthem member, you have the responsibility to:

- Know and understand your rights you have under Ohio Department of Medicaid and Plan.
- Ask questions if you do not understand your rights or responsibilities.
- Follow by the health plan policies and procedures. This includes the responsibility to:
    - Carry your ID card at all times when getting healthcare services.
    - Let us know if your ID card is lost or stolen.
    - Change your PCP or Health Plan per ODM and Anthem policies.
    - Keep your scheduled appointments.
    - Cancel appointments in advance when you cannot keep them.
    - Always contact your PCP first for your nonemergency medical needs.
    - Understand when you should and should not go to the emergency room.
    - Understand how you can obtain care after hours or if your doctor office is closed.
    - Treat providers and staff with respect.
    - Notify Anthem if you have other health insurance.

- Share information about your health, to the best of your ability, your doctors and the Health Plan needs in order to provide you with the right care and treatment options. This includes responsibilities to:
    - Tell your doctor about your healthcare needs and ask questions about your treatment options.
    - Help your doctor to get your medical records.
    - Give your doctor as much accurate information as you are able to.
    - Tell your doctor if you received care somewhere else.
    - Understand your health problems, and

- Work with your doctor to create a care treatment plan and goals specific to your health condition that you both agreed to, as much as possible, including:
    - Understand your treatment options and health services.
    - Work together with your doctor to decide on best available treatment.
    - Understand how what you do can affect your health.
    - Follow plans and instructions for care that you have agreed to with your doctor to stay healthy.

Call Anthem Member Services at **844-912-0938 (TTY 711)** if you have a problem and need help.

Anthem provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability, or type of illness or condition.

FIRST LINE OF DEFENSE AGAINST FRAUD

We are committed to protecting the integrity of our healthcare program and the effectiveness of our operations by preventing, detecting, and investigating fraud, waste, and abuse. Combating fraud, waste, and abuse begins with knowledge and awareness.

- *Fraud* — Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it — or any other person. The attempt itself is fraud, regardless of whether or not it is successful.
- *Waste* — includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- *Abuse* — when healthcare providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

To help prevent fraud, waste, and abuse, talk to your providers. For example, spending time reviewing your records with your provider for prescription administration will help determine if there are any concerns with your prescriptions. One of the most common types of fraud is to share your member ID card with another person. It's important for members to understand that this is considered fraud. Learn more at **https://www.fighthealthcarefraud.com/**.

Presentation of a member identification (ID) card does not guarantee eligibility; providers should verify a member's status by inquiring online or via telephone. Online support is available for provider inquiries on the website, and telephonic verification may be obtained through the automated Provider Inquiry Line at **844-912-1226**.

Protect your ID card as you would a credit card, carry your health benefits card at all times, and report any lost or stolen cards to the company as soon as possible. Understanding the various opportunities for fraud can help prevent fraudulent activities. If you suspect ID theft, call the compliance hotline at **844-912-1226**. If you suspect ID theft, inspect your explanation of benefits (EOBs) for any errors and then contact Member Services if something is incorrect.

Reporting fraud, waste, and abuse

If you suspect a provider (e.g., provider group, hospital, doctor, dentist, counselor, medical supply company, etc.) or any member (a person who receives benefits) has committed fraud, waste, or abuse, you have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

You can report your concerns by:

- Visiting our fighthealthcarefraud.com education site; at the top of the page, click "Report it" and complete the "**Report Waste, Fraud and Abuse**" form.
- Calling Member Services at **844-912-0938 (TTY 711)** Monday through Friday from 7 a.m. to 8p.m. Eastern time.

Any incident of fraud, waste or abuse may be reported to us anonymously; however, our ability to investigate an anonymously reported matter may be handicapped without enough information. Hence, we encourage you to give as much information as possible. We appreciate your time in referring suspected fraud, but be advised that we do not routinely update individuals who make referrals as it may potentially compromise an investigation.

Examples of provider fraud, waste, and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering, or receiving kickbacks or bribes
- Unbundling — when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding — when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address, and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if you have it
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

Examples of member fraud, waste, and abuse

- Forging, altering, or selling prescriptions
- Letting someone else use the member's ID (Identification) card

- Obtaining controlled substances from multiple providers
- Relocating to out-of-service plan area
- Using someone else's ID card

When reporting concerns involving a member, include:

- The member's name
- The member's date of birth, Social Security Number, or case number if you have it
- The city where the member resides
- Specific details describing the fraud, waste, or abuse

Investigation process

We investigate all reports of fraud, waste, and abuse for all services provided under the contract. If appropriate, allegations and the investigative findings are reported to all appropriate state, regulatory and/or law enforcement agencies. In addition to reporting, we may take corrective action with provider fraud, waste, or abuse, which may include, but is not limited to:

- *Written warning and/or education*: We send certified letters to the provider documenting the issues and the need for improvement. Letters may include education or requests for recoveries, or may advise of further action.
- *Medical record review*: We review medical records to substantiate allegations or validate claims submissions.
- *Special claims review*: A certified professional coder evaluates claims prior to payment of designated claims. This edit prevents automatic claim payment in specific situations.
- *Recoveries*: We recover overpayments directly from the provider. Failure of the provider to return the overpayment may result in reduced payment of future claims and/or further legal action.

If you are working with the SIU, all communication (checks, correspondence) should be sent to:
Anthem, Inc.
Special Investigations Unit
740 W Peachtree Street NW
Atlanta, GA 30308
Attn: investigator name, #case number

Paper medical records and claims are a different address, which is supplied in correspondence from the SIU. If you have questions, contact your investigator. An opportunity to submit claims and medical records electronically is an option if you register for an Availity account. Contact Availity Client Services at **800-AVAILITY (282-4548)** for more information.

Acting on investigative findings

We refer all criminal activity committed by a member or provider to the appropriate regulatory and law enforcement agencies.

If a provider appears to have committed fraud, waste, or abuse, the provider:

- Will be referred to the Special Investigations Unit.

- May be presented to the credentials committee and/or peer review committee for disciplinary action, including provider termination.
- Will be referred to other authorities as applicable and/or designated by the State.

Failure to comply with program policy or procedures, or any violation of the contract, may result in termination from our plan.

If a member appears to have committed fraud, waste, or abuse or has failed to correct issues, the member may be involuntarily dis-enrolled from our healthcare plan, with state approval.

WE HOPE THIS BOOK HAS ANSWERED MOST OF YOUR QUESTIONS ABOUT ANTHEM. FOR MORE INFORMATION, CALL MEMBER SERVICES AT 844-912-0938 (TTY 711).

THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN ANTHEM AND THE MEMBER.

MANAGED CARE TERMINOLOGY

Appeal: a member's request for Anthem Blue Cross and Blue Shield to review an adverse benefit determination.

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 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 Anthem Blue Cross and Blue Shield.

Excluded Services: health services that Anthem Blue Cross and Blue Shield 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.

Health Insurance: A contract that requires Anthem Blue Cross and Blue Shield 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. (OAC rule 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.

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.

Network: the Anthem Blue Cross and Blue Shield contracted providers available to Anthem Blue Cross and Blue Shield members.

Non-Participating Provider: any provider with an ODM provider agreement who does not contract with Anthem Blue Cross and Blue Shield but delivers health care services to an Anthem Blue Cross and Blue Shield plan's members.

Participating Provider: any provider, group of providers, or entity that has a network provider contract with the Anthem Blue Cross and Blue Shield plan 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 Anthem Blue Cross and Blue Shield Plan'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. (OAC rule 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. (OAC rule 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 Anthem Blue Cross and Blue Shield plan that a health care service, treatment plan, 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. (OAC rule 5160-26-01(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 Anthem Blue Cross and Blue Shield 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 Anthem Blue Cross and Blue Shield members.

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 Member Handbook Contents

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 **833-491-0344** (**TTY 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-counter (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

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 Medicaid information 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://pharmacy.medicaid.ohio.gov/unified-pdl
- A paper copy can be requested by calling Member Services at **833-491-0344 (TTY 833-655-2437)**

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. These requests will be sent by your prescriber through many different routes (phone, fax, mail, or web portal) to ensure a quick and efficient review of your medication. 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 our decision.

You have the option to call Member Services toll free at **833-491-0344 (TTY 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 or pharmacy alternative 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 case, 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 **833-491-0344** (**TTY 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 **833-491-0344** (**TTY 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:

1. Call Member Services at **833-491-0344** (**TTY 833-655-2437**) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
2. 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.
3. Visit our website at https://spbm.medicaid.ohio.gov.
4. 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. A State 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 **866-635-3748** (**TTY/TDD 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 **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 as OH_MCD_PBM@gainwelltechnologies.com or call Member Services at **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 a provider through the Gainwell Member Portal, you can follow the directions on the website at https://spbm.medicaid.ohio.gov or call your Member Services toll free at **833-491-0344** (**TTY 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 **833-491-0344** (**TTY 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 need any additional services below, please contact Member Services toll free at **833-491-0344** (**TTY 833-655-2437**) to speak to a team member at no additional charge:

1.4.1 Oral interpretation
1.4.2 Translation services
1.4.3 Auxiliary aids and services
1.4.4 Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic
1.4.5 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 **833-491-0344** (**TTY 833-655-2437**).

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files.
  - Destroy paper with health information so others can't get it.
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in.
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - Teach people who work for us to follow the rules.

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it is OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, healthcare operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them (called prior authorization or preapproval)
  - To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations and treatment. If you don't want this, please visit **anthem.com/oh/medicaid** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better

- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We cannot take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, such as if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call **844-203-3796** to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **844-912-0938**. If you're deaf or hard of hearing, call **TTY 711**.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave.
Chicago, Illinois 60601
Phone: 312-353-5160
TDD: 800-537-7697
Fax: 312-353-4144

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **anthem.com/oh/medicaid.**

Race, ethnicity and language

We get race, ethnicity and language information about you from the state Medicaid agency. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **<u>not</u>** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - –Health
  - –Habits
  - –Hobbies
- We may get PI about you from other people or groups like:
  - –Doctors
  - –Hospitals
  - –Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact our Member Services number at **844-912-0938 (TTY 711)** Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Revised March 2024

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Anthem Blue Cross and Blue Shield follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important
For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic, and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at **844-912-0938 (TTY 711)**.

Your rights
Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax, or phone.

Grievance Coordinator
P.O. Box 62429
Virginia Beach, VA 23466-2429

Phone: **844-912-0938 (TTY 711)**
Fax: 866-587-3316
Email: ohioga@anthem.com

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the Web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
200 Independence Ave. SW
Room 509F, HHH Building
Washington, DC 20201
- **By phone:** 800-368-1019 (TTY/TDD 800-537-7697)

For a complaint form, visit **https://www.hhs.gov/civil-rights/filing-a-complaint/index.html**

Ohio Medicaid Managed Care Entity
Member Appeal Form

If you do not agree with a decision made by your managed care entity (MCE), you should contact the MCE as soon as possible. You, or someone you want to speak for you can contact the MCE using this form.

Instructions: Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible, and submit the completed form to the appropriate MCE. To ensure a decision can be made by the MCE, the following documentation should be submitted with the form:

- Attach *copies* of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I – Member Information		
Member Name		Date of Request (mm/dd/yyyy)
Member ID Number	Member Phone Number	Date of Birth (mm/dd/yyyy)
Member Address		
Reason For Request ☐ Service(s) denied, reduced, or ended ☐ Untimely decision on prior authorization request ☐ Payment or claim denied ☐ Other (explain):		
☐ I believe waiting on this decision could seriously jeopardize my life, physical or mental health, or ability to attain, maintain or regain maximum function. I understand by checking this box that it may reduce the amount of time that myself and/or provider have to send in additional information regarding my appeal unless an extension is requested. If no extension is requested and meets criteria, I will receive a decision within 72 hours. ☐ I believe waiting on this decision would not jeopardize my health. Unless an extension is requested, I will receive a decision on my appeal within 15 calendar days.		
Section II – Description of Specific Issue *Please state all details relating to your request including names, dates, places, provider information, and prior authorization request number if known. Attach another sheet of paper to this form if more space is needed.*		
By signing below, you agree that the information provided is true and correct.		
Member's Signature	Date (mm/dd/yyyy)	
If someone else is completing this form for you, you are giving written consent for the person named below to submit on your behalf. By signing below, your authorized representative agrees that the information provided is true and correct.		
Member's Authorized Representative Name (if applicable)	Relationship to Member	
Authorized Representative Signature (if applicable)		
☐ *Check this box if you are a provider submitting this form on behalf of a member. In accordance with Ohio Administrative Code rule 5160-26-08.4, any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCE will begin processing the appeal upon receipt of written consent.*		

Contact and Submission Information				
Aetna OhioRISE	Aetna MyCare	AmeriHealth	Anthem	Buckeye
CareSource	Humana	Molina	United	Gainwell (SPBM)

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Ohio Medicaid Managed Care Entity
Member Grievance Form

If you are unhappy with <Anthem> 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 let us know. <Plan Name> wants to help."

Instructions: Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible.

- Attach *copies* of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I – Member Information

Member Name		**Date of Request** (mm/dd/yyyy)
Member ID Number	**Member Phone Number**	**Date of Birth** (mm/dd/yyyy)
Member Address		

Reason For Request

☐ **Urgent Issue that is keeping you from receiving needed medical care**
☐ Member Billing Issue
☐ Transportation Issue
☐ ID card Issue
☐ Issue with the medical care you received from a provider
☐ Difficulty getting access to Medical care
☐ Unhappy with a Provider office
☐ Issue with Dental services
☐ Other (explain):

Section II – Description of Specific Issue

Please state all details relating to your request including names, dates, places, provider information, and prior authorization request number if known. Anthem will call you to obtain any additional information we need to resolve your issue.

By signing below, you agree that the information provided is true and correct.

Member's Signature	**Date** (mm/dd/yyyy)

If someone else is completing this form for you, you are giving written consent for the person named below to submit on your behalf. By signing below, your authorized representative agrees that the information provided is true and correct.

Member's Authorized Representative Name (if applicable)	**Relationship to Member**
Authorized Representative Signature (if applicable)	

☐ *Check this box if you are a provider submitting this form on behalf of a member. In accordance with Ohio Administrative Code rule 5160-26-08.4, any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCE will begin processing the appeal upon receipt of written consent.*

Contact and Submission Information

<MCE contact information will be inserted here (fax or email information to be gathered from MCEs at later date>

- Contact Member Services Department at [Insert local or toll-free phone and TTY numbers, email address],
- Online by logging into the member portal <URL> look for Grievance form
- Mobile application <sydney> Grievance form.