ambetter. FROM mhs Your Choice for Better Healthcare

Your **2016** Member Handbook

Everything you need to know about your plan:

Covered Services • Pharmacy Benefits • Emergency Services • Wellness Programs

For more information, visit Ambetter.mhsindiana.com

If this information is not in your primary language, please call 1-877-687-1182 (TTY/TDD 1-800-743-3333)

ambetter. FROM mhs Your Choice for Better Healthcare

Welcome to Ambetter from MHS!

Thank you for choosing us as your health insurance plan. We're excited to help you take charge of your health and to help you lead a healthier, more fulfilling life.

As our member, you have access to lots of helpful services and resources. This member handbook will help you understand all of them. Inside, you'll find important information about:

- How your plan works
- Payment information
- Preventive care benefits
- Where to go for care
- Health management programs
- Pharmacy benefits
- Optional adult dental and vision benefits
- And much more!

YOUR HEALTH IS OUR PRIORITY.

If you have questions, we're always ready to help. And don't forget to check out our online video library at Ambetter.mhsindiana.com. It's full of useful information.

Member Services:
1-877-687-1182 (TTY/TDD 1-800-743-3333)

Ambetter.mhsindiana.com

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Member Handbook Overview

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When you call, have these items ready:

- Your ID card
- Your claim number or invoice for billing questions

Schedule of Benefits
Your *Schedule of Benefits* is a list of the benefits your plan covers and when you can receive them.

Evidence of Coverage
Your *Evidence of Coverage* is a list of the benefits your plan offers and how much you will have to pay for them.

Interpreter Services
If you don't feel comfortable speaking English, we provide free interpreter services. Call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333) to learn more.

The Resources You Need. Right Here.

Understanding your health insurance coverage is important. This member handbook explains everything you need to know — so take a look! For information about your specific plan's covered benefits and cost sharing, check out your *Schedule of Benefits* or *Evidence of Coverage*. You can find both in your online member account.

How To Contact Us

Ambetter from MHS
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

If you want to talk, we're available Monday through Friday, 8 a.m. to 5 p.m. EST.

Member Services	1-877-687-1182
Fax	1-877-941-8072
TTY/TDD	1-800-743-3333
Make a Payment	1-877-687-1182
Behavioral Health Services	1-877-687-1182
24/7 Nurse Advice Line	1-877-687-1182
Complaints and Grievances	1-877-687-1182
Emergency	911
Website	Ambetter.mhsindiana.com

How Your Plan Works

Want more information about our service area and in-network providers? Visit Ambetter.MHSindiana.com

So You Have Health Insurance — Now What?

Having health insurance is exciting. To get the most out of your plan, complete this simple checklist.

1. Set up your secure online member account. Do this by visiting the "For Members" page on Ambetter.mhsindiana.com. Your member account stores all of your plan's benefits and coverage information in one place. It gives you access to your *Summary of Benefits* and *Evidence of Coverage*, claims information, this member handbook and more.
2. Complete your online Ambetter Welcome Survey. All you have to do is log in to your online member account. Completing this survey helps us design your plan around your specific needs — and it helps you earn $50 on your My Health Pays™ VISA® Prepaid Card.
3. Enroll in automatic bill pay. Call us or log in to your online member account to sign up. Automatic bill pay automatically withdraws your monthly premium payment from your bank account. It's simple, helpful, convenient and secure.
4. Pick your primary care provider (PCP). Just log in to your member account and view a list of Ambetter providers in your area by using the Provider Directory available on our website. Remember, your PCP, also known as a personal doctor, is the main doctor you will see for most of your medical care. This includes your checkups, sick visits and other basic health needs.
5. Schedule your annual wellness exam with your PCP. After your first checkup, you'll get $50 on your My Health Pays™ VISA® Prepaid Card. And anytime you need care, call your PCP and make an appointment!

If you have questions about paying your bill, give billing services a call at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Make sure we receive your premium payment by its due date. If we don't, we may not pay providers for your medical and prescription claims.

If your coverage is terminated for not paying your premium, you won't be eligible to enroll with us again until Open Enrollment or a Special Enrollment period.

How Can I Pay My Monthly Bill?

1. **Pay online (Our recommendation!)**
   a. Create your online member account on Ambetter.mhsindiana.com and enroll in automatic bill pay. You can set up automatic bill pay using your credit card, prepaid debit card, bank debit card or bank account.
   b. You can also pay by credit card, prepaid debit or bank debit card. Just follow the "pay online" instructions at Ambetter.mhsindiana.com.
2. **Pay by phone**
   a. Pay over the phone by calling billing services at 1-877-687-1182 (TTY/TDD 1-800-743-3333) between 8 a.m. and 5 p.m. EST. You will have the option to pay using the Interactive Voice Response (IVR) system or by speaking to a billing services representative.
3. **Pay by mail**
   a. Send a check or money order to the address listed on your billing invoice payment coupon. **Remember to write your member ID number on the check or money order and detach the payment coupon from the billing invoice and mail with your payment.**

What Happens If I Pay Late?

Your bill is due before the first day of every month. For example, if you are paying your premium for June, it will be due May 31.

If you don't pay your premium before its due date, you may enter a grace period (learn more on page 6). During your grace period, you will still have coverage. However, if you don't pay before a grace period ends, you run the risk of losing your coverage. During a grace period, we may hold — or pend — payment of your claims.

Deciding whether or not you need to visit the emergency room can be tricky. Call our 24/7 nurse advice line at 1-877-687-1182. They can help you decide where to go for care.

Have total or partial hearing loss? Call TTY/TDD 1-800-743-3333 or visit Ambetter.mhsindiana.com

Member Services

We want you to have a great experience with Ambetter. Our Member Services Department is always here for you. They can help you:

- Understand how your plan works
- Learn how to get the care you need
- Find answers to any questions you have about health insurance
- See what your plan does and does not cover
- Pick a primary care provider (PCP) that meets your needs
- Get more information about helpful programs, like Care Management
- Find other healthcare providers (like in-network pharmacies and labs)
- Request your member ID card or other member materials

24/7 Nurse Advice Line

Our free 24/7 nurse advice line makes it easy to get answers to your health questions. You don't even have to leave home! Staffed by registered nurses, our 24/7 nurse advice line runs all day, every day. Call 1-877-687-1182 if you have questions about:

- Your health, medications or a chronic condition
- Whether you should go to the emergency room (ER) or see your PCP
- What to do for a sick child
- How to handle a condition in the middle of the night
- Accessing our online health information library

Membership & Coverage Information

For information about enrollment options and specific plan benefits, check out Ambetter.mhsindiana.com

Important Coverage Details

Your Ambetter coverage is good for as long as you continue to pay your premium and meet the eligibility requirements of the Health Insurance Marketplace.

We promise we won't discriminate against your income, health history, physical or mental condition, age, gender, sexual orientation, religion, physical or mental disability, ethnicity or race, previous status as a member, pre-existing conditions and/or expected health or genetic status.

Grace Periods

If you don't pay your premium by its due date, you'll enter a grace period. This is the extra time we give you to pay (we understand that stuff happens sometimes).

During your grace period, you will still have coverage. However, if you don't pay before a grace period ends, you run the risk of losing your coverage. During a grace period, we may hold — or pend — your claim payment.

If your coverage is terminated for not paying your premium, you won't be eligible to enroll with us again until Open Enrollment or a Special Enrollment period. So make sure you pay your bills on time!

If you receive a subsidy payment:
After you pay your first bill, you have a three-month grace period. During the first month of your grace period, we will keep paying claims for covered services you receive. If you continue to receive services during the second and third months of your grace period, we may hold these claims. If your coverage is in the second or third month of a grace period, we will notify you and your healthcare providers about the possibility of denied claims. We will also notify the U.S. Department of Health and Human Services (HHS) that you haven't paid your premium.

If you don't receive a subsidy payment:
After you pay your first bill, you have a grace period of one month. During this time, we will continue to cover your care, but we may hold your claims. We will notify you, your providers and the HHS about this non-payment and the possibility of denied claims.

Every time you receive care, make sure to stay within the Ambetter network.

Get your free copy of our *Provider Directory* by calling Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

A *Provider Directory* is a listing of providers near you.

Finding The Right Care

We're proud to offer you quality care in Indiana. Our local provider network is the group of doctors, hospitals and other healthcare providers who have agreed to provide you with your healthcare services.

To search our *Provider Directory*, visit Ambetter.mhsindiana.com/findadoc and use our Find a Provider tool. This tool will have the most up-to-date information about our provider network. It can help you find a primary care provider (PCP), pharmacy, lab, hospital or specialist. You can narrow your search by:

- Provider specialty
- ZIP code
- Gender
- Languages spoken
- Whether or not he/she is currently accepting new patients

Your Ambetter Member ID Card

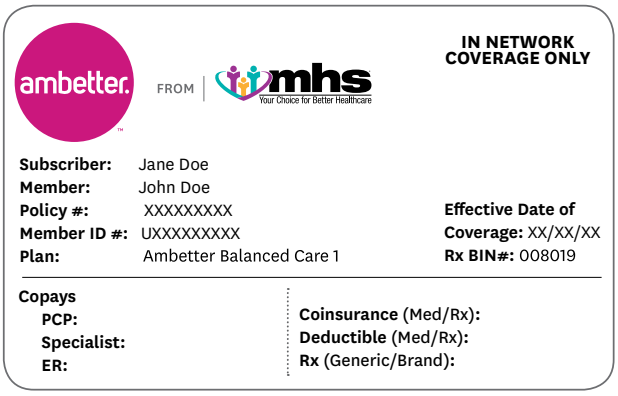
Your member ID card is proof that you have health insurance with us. It may seem small, but it's very important.

Here are some things to keep in mind:

- Keep this card with you at all times
- You will need to present this card anytime you receive healthcare services
- You should have received your Ambetter member ID card with your member welcome packet materials. If you don't get your member ID card before your coverage begins, call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333). We will send you another card.

If you need a temporary ID card or if you would like to request a new one, log in to your secure member account.

Here is an example of what a member ID card typically looks like:



Front

Ambetter.mhsindiana.com

Member/Provider Services:
1-877-687-1182
TDD/TTY: 1-800-743-3333
24/7 Nurse Line: 1-877-687-1182

Numbers below for providers:
Pharmacy Help Desk: 1-855-339-4810
EDI Payor ID: 68069
EDI Help Desk: Ambetter.mhsindiana.com

Medical Claims:
Managed Health Services
Attn: CLAIMS
PO Box 5010
Farmington, MO
63640-5010

Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetter.mhsindiana.com.

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Visit us online at Ambetter.mhsindiana.com!

Our website helps you get the answers you need to get the right care, the right way, including a secure portal for you to check the status of your claim, view your *Evidence of Coverage* (EOC) or understand your out-of-pocket costs, copays and progress toward deductible.

Get Online And Get In Control

Did you know you can always access helpful resources and information about your plan? It's all on our website! Visit Ambetter.MHSindiana.com and take charge of your health.

On our website, you can:

- Find a primary care provider (PCP)
- Locate other providers, like a pharmacy
- Find health information
- Learn about programs and services that can help you get and stay healthy

Use your online member account to:

- Pay your monthly bill
- Print a temporary ID card or request a new one
- View your claims status and payment information
- Read your member materials (your *Evidence of Coverage*, *Schedule of Benefits*, this handbook)
- Track your My Health Pays™ rewards
- Complete your health assessment

!

Every time you receive care, make sure to stay within the Ambetter network. You will be responsible for additional costs when you seek care outside of the Ambetter network.

Prior authorization means a service needs to be approved before you go to the provider.

Your *Schedule of Benefits* can be found online. Just log in to your online member account.

What Does Your Plan Cover?

We want to meet your healthcare needs. So our plans provide coverage for a wide range of medical and behavioral health services.

For a service to be covered and eligible for reimbursement, it must be:

- Described in your policy
- Medically necessary
- Prescribed by your treating provider or primary care provider (PCP)
- Authorized by us (when required)
  - For example:
    - Services from or visits to an out-of-network provider
    - Certain surgical procedures
    - Inpatient admissions

Want to see if a service needs authorizing or check on the status of a service you submitted for authorization? Call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333). If you do not have prior authorization before you receive the services, you may be held responsible for total payment. You can learn more about prior authorizations on page 36.

You can find information about your specific copayments, cost sharing and deductible in your *Schedule of Benefits*. For a list of exclusions, refer to your *Evidence of Coverage*.

Remember to use an in-network provider when you get your preventive care services. Use our Find a Provider tool on Ambetter.MHSindiana.com to see if a provider is in-network.

To see all of your covered preventive care services, refer to your *Evidence of Coverage*.

Here's What Your Plan Covers

Preventive care services are regular health checkups that are designed to catch problems before they start. Stay up-to-date with these services — they can help you stay healthy! Be sure to schedule appointments for your preventive care visits.

We cover these preventive care services:		
For all adults	**For women**	**For infants, children and adolescents**
• Annual wellness exams • Blood pressure screenings • Cholesterol screenings • Immunizations and vaccines, like the flu vaccine, as recommended by the Centers for Disease Control and Prevention (CDC)	• Annual well-woman exams • Mammography exams • Breastfeeding support and supplies • Pregnancy-related services - RH incompatibility screenings - Gestational diabetes screenings - Iron deficiency screenings	• Well-child visits • Immunizations and vaccines, as recommended by the CDC • Newborn screenings, like a hearing screening and a PKU (Phenylketonuria) screening • Developmental screenings for children age 3 and under • Obesity screenings and counseling

We cover:

- Preventive services that are recommended by the United States Preventive Services Task Force as a Grade A or B. Use this link to view all preventive services covered at no cost under the Affordable Care Act
- Immunizations and vaccines recommended by the CDC
- Women's preventive care supported by the Health Resources and Services Administration (HRSA)
- The schedule of wellness visits for infants, children and adolescents recommended by the American Academy of Pediatrics

Refer to your *Evidence of Coverage* to get the details for each covered service. Some have certain exclusions and limitations.

We only cover in-network services (unless it's an emergency service). If you go to an out-of-network provider without prior approval, you will be responsible for all costs associated with those services. Make sure your providers are in network by using our Find a Provider tool on Ambetter.mhsindiana.com

Your Plan Also Covers:

- Acquired brain injury services
- Ambulance services
- Autism Spectrum Disorder services
- Behavioral health services and benefits for mental healthcare
- Emergency care
- Habilitation, rehabilitation and extended care facility benefits
- Home healthcare services
- Hospice care
- Medical and surgical benefits, including:
  - Hospital services
  - Surgery services
  - Physician services primary care provider (PCP)
  - Professional services
  - Medical supplies
  - Diagnostic testing
  - Chemotherapy
  - Hemodialysis
  - Anesthetics
  - Oxygen
  - Dental services as result of an injury
  - Diabetic equipment and supplies
  - Chiropractic services
  - Maternity care
  - Durable medical equipment
  - Speech and hearing benefits
  - Outpatient prescription benefits (see *Pharmacy Benefits* on page 17)
  - Preventive healthcare services
  - Transplant services
  - Pediatric vision services

Your plan may include:*

- Routine adult vision services (preventive eye exams, glasses and/or contact lenses)
- Preventive and basic adult dental services
- Three free visits as a part of your benefits. This includes only the actual visit with your PCP. Any labs, radiology (X-rays), minor surgeries or other services provided during the visit will be subject to your deductible and co-insurance. Preventive care visits, such as your annual well-visit exam, are not included as part of the free visits. We cover your preventive care visits separately.

*Coverage varies depending on your plan. See your *Schedule of Benefits* for your specific coverage information.

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Your *Evidence of Coverage* has a full list of coverage limitations and exclusions, plus a list of which healthcare services are covered on your particular plan.

The Ambetter Drug Formulary has a complete list of all covered medications. Read your copy at Ambetter.mhsindiana.com

What's Not Covered?

We offer many important wellness benefits and health screenings. However, there are still some things that your coverage doesn't include.

Usually, we only cover services and supplies that are:

- Administered or ordered by your physician
- Medically necessary to diagnose or treat your injury or illness
- Covered under preventive care

In general, we don't cover:

- Services or supplies that are provided before coverage begins or after it ends
- Charges that are greater than the eligible service expense
- Weight control services
- Infertility services or medications
- Breast reduction or augmentation (unless medically necessary)
- Cosmetic treatment (except for reconstructive surgery following a covered surgery or injury, or services that are performed to correct a birth defect in a child who has been a member since birth)
- Diagnosis or treatment of learning disabilities, attitudinal disorders or disciplinary problems
- Eye refractive surgery (to correct nearsightedness, farsightedness or astigmatism)
- Experimental or investigative treatment or unproven services
- Treatment received outside the United States (except for a medical emergency while traveling for up to 90 consecutive days)
- Intentionally self-inflicted bodily harm
- Illness or injury incurred as a result of a member's intoxication, except as expressly provided for under the Mental Health and Substance Use Disorder benefits provision
- Services or expenses for alternative treatments, including acupressure, acupuncture, aromatherapy, hypnotism, massage therapy rolfing and other forms of alternative treatment

Be sure to call us and report your emergency within one business day. You don't need prior approval for emergency care.

If you receive a provider bill that doesn't reflect your cost share as listed in your *Schedule of Benefits*, call Member Services right away: 1-877-687-1182 (TTY/TDD 1-800-743-3333).

How To Get Medical Care When You're Out Of Town

When you're outside of the service area, we can't cover your routine or maintenance care. However, we do cover emergency care out of the service area.

If you are temporarily out of the area and have a medical or behavioral health emergency, call 911 or go to the nearest emergency room. Be sure to call us and report your emergency within one business day. You don't need prior approval for emergency care.

Provider Billing: What To Expect

After receiving medical care, you may get a bill from your provider. Providers can only bill you for your share of the cost of covered services. This includes your deductible, copayment and cost sharing percentage. If you receive a provider bill that doesn't reflect your cost share as listed in your *Schedule of Benefits*, contact us right away. This is very important.

When receiving care at one of our in-network hospitals, it is possible that some hospital-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with us as in-network providers. These providers may bill you for the difference between our allowed amount and the provider's billed charge — this is known as "balance billing." We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with us.

You can call Member Services, or mail or fax us the bill or statement you received. We will find out why the provider sent you a bill and get back to you as quickly as possible.

Ambetter from MHS
1099 N. Meridian Street Suite 400
Indianapolis, IN 46204

Ambetter Member Services: 1-877-687-1182
TTY/TDD: 1-800-743-3333
Fax: 1-877-941-8072

How To Submit A Claim For Covered Services

Providers will typically submit claims on your behalf, but sometimes you may be financially responsible for covered services. This usually happens if your provider is not contracted with us.

If you have paid for services we agreed to cover, you can request reimbursement for the amount you paid. We can adjust your deductible, copayment or cost sharing to reimburse you.

To request reimbursement for a covered service, you need a copy of the detailed claim from the provider. You also need to submit an explanation of why you paid for the covered services. Send this to us at the following address:

Ambetter from MHS
Attn: Claims Department
P.O. Box 5010
Farmington, MO 63640-5010

After getting your claim, we will let you know we have received it, begin an investigation and request all items necessary to resolve the claim. We will do this in 15 days or less.

We will notify you, in writing, that we have either accepted or rejected your claim for processing within 15 days as well. If we are unable to come to a decision about your claim within 15 days, we will let you know and explain why we need additional time.

We will accept or reject your claim no later than 45 days after we receive it. If we reject your claim, the notice will state the reason why. If we agree to pay all or part of your claim, we will pay it no later than the fifth business day after the notice has been made.

If you need care that your PCP cannot provide, he/she can recommend a specialist provider. Paper referrals aren't required.

When Do You Need a Referral?

If you have a specific medical problem, condition, injury or disease, you will probably need to see a specialist. A specialist is a provider who is trained in a specific area of healthcare. To see a specialist, you should get a referral from your primary care provider (PCP).

Here are some services that may require a referral from your PCP:

- Specialist services, including standing or ongoing referrals to a specific provider
- Diagnostic tests (X-rays and labs)
- High-tech imaging (CT scans, MRIs, PET scans, etc.)*
- Scheduled outpatient hospital services
- Planned inpatient admission*
- Clinic services
- Renal dialysis (for kidney disease)
- Durable medical equipment (DME)*
- Home healthcare*

*Requires prior authorization from Ambetter.

Your Primary Care Provider

When you see your PCP, always remember to bring your member ID card and a photo ID!

Remember to select an in-network PCP! Check out our *Provider Directory* for a full list of your options and their contact information. It's on the Find a Provider page of Ambetter.mhsindiana.com/findadoc.

If you don't select a PCP, we may assign you to one. See page 19 to choose your PCP today.

Seeing your PCP for regular checkups helps you find problems early and qualifies you for a reward on your My Health Pays™ account.

When you became a member, you may have selected your PCP. If you didn't, we may assign you to a PCP. You can change your PCP at any time. To learn more, visit Ambetter.mhsindiana.com

To learn more about a specific PCP, call 1-877-687-1182 (TTY/TDD 1-800-743-3333). You can also see our provider list on the Find a Provider page at Ambetter.mhsindiana.com

What's A Primary Care Provider?

Your primary care provider (PCP) is your main doctor. He/she is also known as your personal doctor. Your PCP is the person you should see for all aspects of your healthcare — from your preventive care to your basic health needs and more. When you're sick and don't know what to do, you should contact your PCP.

You need to have a PCP. If you haven't chosen one, it's time to do so. See page 19 for help selecting your PCP. After you pick a PCP, schedule a preventive care visit. Remember, you should get to know your PCP and establish a healthy relationship — get started today!

Your PCP will:

- Provide preventive care
- Give you regular physical exams as needed
- Conduct regular immunizations as needed
- Deliver timely service
- Work with other doctors when you receive care somewhere else
- Coordinate specialty care with Ambetter
- Provide any ongoing care you need
- Update your medical record, which includes keeping track of all the care that you get from all of your providers
- Treat all patients the same way
- Make sure you can contact him/her or another provider at all times
- Discuss what advance directives are and file directives appropriately in your medical record

Picking The Right PCP

You can select any available PCP in our network. The choice is up to you! You will be able to choose from:

- Family practices
- General practitioners
- Internal medicine
- Obstetricians/gynecologists (female members)
- Pediatricians (for children)

Are you having trouble getting an appointment with your PCP? Do you need help with your follow-up care? Call Member Services: 1-877-687-1182 (TTY/TDD 1-800-743-3333). We're here to help.

You can call your PCP's office for information on receiving after-hours care in your area. If you have an urgent medical problem or question and cannot reach your PCP during normal office hours, you can call the 24/7 Nurse Advice Line at 1-877-687-1182 (TTY/TDD 1-800-743-3333). If you have an emergency, call 911 or go to the nearest emergency room.

Making An Appointment With Your PCP

To make an appointment with your primary care provider (PCP), call his/her office during business hours and set up a time and date. If you need to cancel or change your appointment, call 24 hours ahead of time. At every appointment, make sure you bring your member ID card and a photo ID.

How long should it take to get an appointment?

You should be able to make an appointment with your PCP in a timely manner. Match your appointment type with its access standard. Each access standard is the typical waiting period you can expect to get an appointment. Your provider should make sure you see them within that timeframe. Here are some general guidelines to follow:

Appointment Timeframe Standards:	
Appointment Type	**Access Standard (waiting period)**
PCP	
Routine visits	30 calendar days
Adult sick visit	48 hours
Pediatric sick visit	24 hours
Behavioral Health	
Routine visits	10 business days
Urgent care	48 hours
Non-life threatening emergency	Within 6 hours
Emergency Providers	
Adult and child	Immediately (24 hours a day, 7 days a week) and without prior authorization
Other	
Specialist	30 calendar days
Urgent care providers	24 hours
Initial visit — pregnant women	14 calendar days
Initial Health Check (EPSDT)	30 calendar days of enrollment

Our 24/7 nurse advice line is always open. Call us with your health questions: 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Care Around The Clock

Sometimes, you need medical help when your primary care prodiver's (PCP's) office is closed. If this happens, don't worry. Just call our 24/7 nurse advice line at 1-877-687-1182 (TTY/TDD 1-800-743-3333). A registered nurse is always available and ready to answer your health questions. In an emergency, call 911 or head straight to the nearest emergency room.

We encourage you to always see a provider who is in network with Ambetter. The Ambetter plans do include services to providers outside of the Ambetter network. Please refer to your *Schedule of Benefits* to make sure that you understand the cost sharing you may be responsible for if you choose to see providers outside of our network.

Selecting A Different PCP

We want you to be happy with the care you receive from our providers. So if you would like to change your PCP for any reason, visit Ambetter.mhsindiana.com. Log in to your online member account and follow these steps:

1. **Click on the "My Health" heart icon on your account home page.**
2. **On your current health overview page, click "Choose Provider."**
3. **Pick a PCP from the list. Make sure you select a PCP who is currently accepting new patients.**

To find another provider or specialist in our network, check out our provider list on the Find a Provider page at Ambetter.mhsindiana.com/findadoc.

What Happens If Your Provider Leaves Our Network?

If your primary care provider (PCP) is planning to leave our provider network, we will send you a notice 30 days before the date he/she intends to leave (or as soon as we know). Please contact Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333) as soon as you know that your PCP is leaving. We can help you choose a new PCP. We will also continue to cover your PCP health services — according to the terms of your *Evidence of Coverage* — for at least 90 days after your PCP disenrolls.

If you are in your second or third trimester of pregnancy when your PCP disenrolls, you may continue to see your PCP until you have delivered your baby and completed your first postpartum visit. You will be able to do this as long as your PCP's disenrollment isn't for quality-related reasons or fraud. If you are terminally ill, you may continue to see your PCP indefinitely with a prior authorization.

If you have a specialist that disenrolls from our provider network, please call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333). We will work with you to ensure your care continues. We will also help you find another specialist within our network.

In order to keep providing coverage as noted above, the PCP or specialist has to agree to:

- Accept our reimbursement as a full payment — at the same rate it was prior to him/her leaving our network
- Not charge copayment amounts that exceed your copayments prior to disenrollment
- Stick to our quality assurance standards and to providing necessary medical information related to your care
- Follow our policies and procedures, including procedures regarding referrals, authorization requirements and, if applicable, the delivery of services according to our treatment plan

!

If you need emergency service, check out our emergency care section: page 24.

Remember: We only provide coverage for out-of-network providers if it is an emergency service or if it is approved with prior authorization.

What About Providers That Aren't In-Network?

You should always try to see providers that are in our network. But if you need to see an out-of-network provider, you will need to arrange care with your PCP and get approval from us. We have to approve an appointment with any out-of-network provider before you get non-emergency or non-urgent treatment.

If we approve your appointment with an out-of-network provider, your copayment and deductible will not change. We will let you know when the authorization is approved. If you don't receive our prior authorization, we cannot provide any benefit, coverage or reimbursement. You will be financially responsible for any and all payments.

When receiving care at one of our in-network hospitals, it is possible that some hospital-based providers (for example, anesthesiologists, radiologists, pathologists) may not be under contract with us as in-network providers. These providers may bill you for the difference between our allowed amount and the provider's billed charge — this is known as "balance billing." We encourage you to inquire about the providers who will be treating you before you begin your treatment, so you can understand their participation status with us.

Where to Go For Care

Call our 24/7 nurse advice line anytime: 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Get The Right Care At The Right Place

When you need medical care, you need to be able to quickly decide where to go or what to do. Get to know your options! They include:

1. **Calling our 24/7 nurse advice line**
2. **Making an appointment with your primary care provider (PCP)**
3. **Visiting an urgent care center**
4. **Going to the emergency room (ER)**

Your decision will depend on your specific situation. The next section describes each of your options in more detail, so keep reading.

And remember — always make sure your providers are in network. Using in-network providers can save you money on your healthcare costs. Every time you receive medical care, you will need your member ID card.

What To Do If Your Condition Isn't Life Threatening

Call our 24/7 nurse advice line or visit your PCP.

Call our 24/7 nurse advice line if you need:
• To know whether you should seek medical treatment immediately • Help caring for a sick child • Answers to questions about your health

Visit your PCP if you need:
• Help with medical problems such as colds, flus and fevers • Treatment for an ongoing health issue like asthma or diabetes • A general checkup • Vaccinations • Advice about your overall health

When To Go To An Urgent Care Center

An urgent care center provides fast, hands-on care for illnesses or injuries that aren't life threatening but still need to be treated within 24 hours. Typically, you will go to an urgent care if your PCP cannot get you in for a visit right away.

Common urgent care issues include:

- Sprains
- Ear infections
- High fevers
- Flu symptoms with vomiting

If you think you need to go to an urgent care center, follow these steps:

- Call your PCP. Your PCP may give you care and directions over the phone or direct you to the right place for care.
- If your PCP's office is closed, you can do one of two options:
    1. Visit our website, Ambetter.mhsindiana.com/findadoc, type in your ZIP code, select "Other." In the "Select Specialty" dropdown, go to "Specialty Clinic, Clinic/Center: Urgent Care."
    2. Call our 24/7 nurse advice line at 1-877-687-1182 (TTY/TDD 1-800-743-3333). A nurse will help you over the phone or direct you to other care. You may have to give the nurse your phone number.

Check your *Schedule of Benefits* to see how much you must pay for urgent care services.

!

Have your member ID card and photo ID ready. You will need them whenever you receive any type of care.

Urgent care is not emergency care. Only go to the ER if your doctor tells you to or if you have a life-threatening emergency.

Always make sure your providers are in network. Using in-network providers can save you money on your healthcare costs.

Not sure if you are experiencing an emergency? Call our 24/7 nurse advice line: 1-877-687-1182 (TTY/TDD 1-800-743-3333).

When To Go To The Emergency Room (ER)

Anything that could endanger your life (or your unborn child's life, if you're pregnant) without immediate medical attention is considered an emergency situation. Emergency services treat accidental injuries or the onset of what appears to be a medical condition. We cover emergency medical and behavioral health services both in and out of our service area. We cover these services 24/7.

Go to the ER if you have:
• Broken bones • Bleeding that won't stop • Labor pains or other bleeding (if you're pregnant) • Severe chest pains or heart attack symptoms • Overdosed on drugs • Ingested poison • Bad burns • Shock symptoms (sweat, thirst, dizziness, pale skin) • Convulsions or seizures • Trouble breathing • The sudden inability to see, move or speak • Gun or knife wounds

Don't go to the ER for:
• Flus, colds, sore throats or earaches • Sprains or strains • Cuts or scrapes that don't require stitches • More medicine or prescription refills • Diaper rash

If you go to an out-of-network ER and you aren't experiencing a true emergency, you may be responsible for any amounts above what your plan covers. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

!

If your life (or your unborn child's life) is at risk, go to the ER.

Depending on your plan, you may have to pay a copay for emergency care.

ERs Are For Emergencies Only

If you go to the ER when you don't need immediate medical or emergency attention, you may wind up waiting longer and paying more. So it's very important to only use the ER for real emergencies.

If you aren't sure if you need emergency care, that's OK. Call your PCP first. He/she will tell you what to do. If your PCP is unavailable, call our 24/7 nurse advice line at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If your condition is severe, always call 911 or go to the nearest ER. You can use any hospital to receive emergency services. In the event of an emergency, it's OK for you to visit hospitals that are out of our network. However, you or someone acting on your behalf must call us and your PCP within one business day of your admission. This will help your PCP arrange any follow-up care you may need.

You can get emergency behavioral health services by calling 911 and connecting to your local pre-hospital emergency medical service system. We won't deny you coverage for medical and transportation expenses for emergency behavioral health conditions.

Health Management Programs

Care Management programs help you manage complex health conditions. Disease Management programs help you manage a specific health condition. Have more questions? Call Member Services: 1-877-687-1182 (TTY/TDD 1-800-743-3333).

We Make It Easier To Manage Your Health

We are committed to providing quality healthcare for you and your family. We want to get you healthy, keep you healthy and help you with any illness or disability.

To help you manage your health, we provide several programs: Care Management, Disease Management and Start Smart for Your Baby®, our healthy pregnancy and family planning program. These helpful programs are all included in your plan for free.

The next section will review these programs and help you sign up, if you are eligible.

Care Management Programs

We understand special health needs and are prepared to help you manage any that you may have. Our Care Management services can help with complex medical or behavioral health needs. If you qualify for Care Management, we will partner you with a care manager. Care managers are registered nurses or social workers that are specially trained to help you:

- Better understand and manage your health conditions
- Coordinate services
- Locate community resources

Your care manager will work with you and your doctor to help you get the care you need. If you have a severe medical condition, your care manager will work with you, your primary care provider (PCP) and managing providers to develop a care plan that meets your needs and your caregiver's needs.

If you think you could benefit from our Care Management or Disease Management programs, please call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Are you ready to quit smoking? If you smoke, this is the most important thing you can do for your health. We know how hard it can be to quit, so we are here to help. Our tobacco cessation program provides you with the support and information you need to quit once and for all.

Disease Management Programs

If you have a chronic condition or specific health problem, our Disease Management program can help. We partner with a nationally recognized Disease Management program to provide Disease Management services. These services include telephonic outreach, education and support. We want you to be able to feel confident, understand and control your condition, and have fewer complications.

We offer Disease Management programs for:

- Asthma – child and adult
- Coronary Artery Disease (heart disease) – age 30+
- Depression
- Diabetes – child and adult
- Hyperlipidemia
- Hypertension (high blood pressure) and high cholesterol
- Lower back pain
- Tobacco cessation – age 18+
- TeleCare Management (TCM) is also available if Care Management deems it necessary.

If you're pregnant, let us know as soon as possible! Please call us at 1-877-687-1182 (TTY/TDD 1-800-743-3333) or log in to your secure member account and complete a Notification of Pregnancy form.

We want to help you take care of yourself and your baby during your pregnancy. To enroll in Start Smart for Your Baby®, contact Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Abortion is not considered a family planning service.

Family Planning Services

Family planning services can help you prevent pregnancy. These services include:

- Birth control counseling
- Education about family planning
- Examination and treatment
- Laboratory examinations and tests
- Medically approved methods and procedures
- Pharmacy supplies and devices

Pre-Pregnancy and Pregnancy Services

- See your doctor before you get pregnant to get your body ready for pregnancy
- Go to the doctor as soon as you think you are pregnant. To stay healthy and get off to a good start, you and your baby need to see a doctor as early as possible.
- Take care of yourself! Maintain healthy lifestyle habits like exercising, eating balanced healthy meals and resting for 8-10 hours at night.
- Do not use tobacco, alcohol or drugs now or while you're pregnant

Start Smart for Your Baby®

If you are pregnant, Start Smart for Your Baby® is our special pregnancy program that's designed just for you. Through Start Smart for Your Baby®, you receive the resources and support that can help you during the stages of pregnancy and infancy. Contact Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333) to learn more or to sign up.

Programs That Reward

Our fitness and wellness programs can help you stay healthy. They can also help you earn money. Take charge of your health — and get rewarded for it.

Check your *Schedule of Benefits* for the specific amounts that you can get reimbursed for going to the gym. To get reimbursed, make sure to file your claim no later than three months after the year for which you are requesting the benefit.

Track your My Health Pays™ rewards on your online member account. Sign up to see your rewards today.

My Health Pays™ Program

My Health Pays™ rewards you for receiving your annual preventive services.

You can earn up to $365 annually on your My Health Pays™ VISA® Prepaid Card.

$50	Complete your online Ambetter Welcome Survey during the first 90 days of your 2016 membership
$50	Get your annual wellness exam with your primary care provider (PCP)
$25	Receive your annual flu vaccine in the fall (9/1-12/31)
$20	Visit the gym at least eight times a month

Use your rewards to help pay for:

- Doctor copays*
- Deductibles
- Your monthly premium payments

Once you earn rewards, we automatically put them on your My Health Pays™ VISA® Prepaid Card — there's nothing extra you have to do! For a full list of covered items, log into your online secure member account. You can also learn more about how to spend your rewards, check your balance and more.

*My Health Pays rewards cannot be used for pharmacy copays.

Gym Reimbursement Program

Healthy lifestyle choices should be affordable. To help you stay healthy and active, we will reimburse you for using a health club or gym on a regular basis. When you participate in our gym reimbursement program, we will reimburse a portion of your monthly dues onto your My Health Pays™ VISA® Prepaid Card. For details, visit Ambetter.mhsindiana.com.

If we don't grant prior authorization, we will notify you and your provider, and provide information regarding the appeal process. See *Member Complaint and Appeals Process* on page 38 for more information.

Mental Health and Substance Use Disorder Services

If you need help, you will be able to get it. We provide mental health and substance-use disorder benefits without discriminating. These services cover the diagnosis and medically necessary active treatment of:

- Mental health disorders
- Substance use disorders

Your copayments, deductibles and treatment limits for behavioral health services work the same as they do for your physical health services.

You can choose any provider in our behavioral health network. You don't need a referral from your primary care provider (PCP).

Some behavioral health services may require prior authorization. Please refer to your *Evidence of Coverage* or contact Member Services for more details.

Pharmacy Benefits

For the most current Ambetter formulary, visit Ambetter.mhsindiana.com or call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you want more information about our pharmacy program, visit Ambetter.mhsindiana.com or call 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Coverage For Your Medications

Our pharmacy program provides high-quality, cost-effective medication therapy. We work with providers and pharmacists to ensure that we cover medications used to treat a variety of conditions and diseases. When ordered by a provider, we cover prescription medications and certain over-the-counter medications.

Our pharmacy program does not cover all medications. Some medications require prior authorization or have limitations on age, dosage and maximum quantities. Please refer to the Ambetter Drug List for a complete list of all covered medications.

For more details on your outpatient prescription drug coverage, read your *Evidence of Coverage* — you can find it on your online member account at Ambetter.mhsindiana.com.

Ambetter Drug List

Our Ambetter Drug List, or formulary, is the list of prescription drugs we cover. The formulary includes drugs you receive at retail pharmacies and our mail-order pharmacy. The Ambetter Pharmacy and Therapeutics (P&T) Committee continually evaluates our formulary to make sure we are using medications in the most appropriate and cost-effective way. The P&T Committee consists of physicians, pharmacists and other healthcare professionals that represent local interests.

Definition of formulary — The formulary is a guide to available brand and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. Generic drugs have the same active ingredients as their brand name counterparts and should be considered the first line of treatment. The FDA requires generics to be safe and work the same as brand name drugs. If there is no generic available, there may be more than one brand name drug to treat a condition. Preferred brand name drugs are listed on Tier 2 to help identify brand drugs that are clinically appropriate, safe and cost-effective treatment options, if a generic medication on the formulary is not suitable for your condition.

Please note, the formulary is not meant to be a complete list of the drugs covered under your prescription benefit. Not all dosage forms or strengths of a drug may be covered. This list is periodically reviewed and updated and may be subject to change. Drugs may be added or removed, or additional requirements may be added in order to approve continued usage of a specific drug.

Specific prescription benefit plan designs may not cover certain products or categories, regardless of their appearance in the formulary. Please check your benefits for coverage limitations and your share of cost for your drugs.

If you have more than one prescription you take regularly, our home delivery program might be right for you. When you enroll, you can get your prescriptions safely delivered right to your door. To sign up for home delivery, call our mail-order pharmacy at 1-800-785-4197.

Over-The-Counter (OTC) Prescriptions

We cover a variety of OTC medications. You can find a list of covered OTC medications in our formulary — they will be marked as "OTC." Our formulary covers your prescriptions when they're from a licensed provider. Your prescription must meet all legal requirements.

How To Fill A Prescription

Filling a prescription is simple. You can have your prescriptions filled at an in-network retail pharmacy or through our mail-order pharmacy.

If you decide to have your prescription filled at an in-network pharmacy, you can use our Provider Directory to find a pharmacy near you. You can access the Provider Directory at Ambetter.mhsindiana.com on the Find a Provider page. This tool will not only let you search for doctors, but also for hospitals, clinics and pharmacies. You can also call a Member Services representative to help you find a pharmacy. At the pharmacy, you will need to provide the pharmacist with your prescription and your member ID card.

We also offer a three-month (90-day) supply of maintenance medications by mail or from in-network retail pharmacies for specific benefit plans. These drugs treat long-term conditions or illnesses, such as high blood pressure, asthma and diabetes. You can find a list of covered medications on Ambetter.mhsindiana.com. We can also mail you the list directly.

Adult Dental Benefits

We offer dental coverage. Call 1-877-687-1182 (TTY/TDD 1-800-743-3333) to sign up or learn more.

Remember: Always use in-network providers for your dental care. To view a list of our dental providers, visit Ambetter.mhsindiana.com

Adding Dental Coverage To Your Plan

Keep your teeth healthy by adding an adult dental care package to your plan (children 19 and under already have pediatric dental benefits). You can get our optional dental care plan for a small monthly charge. Dental coverage has an annual maximum that applies to all covered services and copayments for certain services.

Our dental care package provides coverage for:

- Basic preventive care (X-rays and cleanings)
- Some restorative care (fillings and extractions)

Members must visit an in-network provider. You will be financially responsible for payment of the service(s) if you see an out-of-network provider.

Adult Vision Benefits

Adding Vision Care To Your Plan

We offer an optional vision care package for adults (children 19 and under already have vision benefits). You can add vision care to your current plan for a small monthly charge. Our vision care package includes:

- Routine eye exams
- Prescription eyeglasses
- Contact lenses

For information regarding your specific copayments and/or deductible, see your *Schedule of Benefits*.

Utilization Management

Visit Ambetter.mhsindiana.com to check your authorization and benefit coverage.

What Is Utilization Management?

We want to make sure you get the right care and services. Our utilization management process is designed to make sure you get the treatment you need.

We will approve all covered benefits that are medically necessary. Our Utilization Management (UM) Department checks to see if the service needed is a covered benefit. If it is covered, the UM nurses check to see if the service is medically necessary. They do this by reviewing the medical notes and talking with your doctor. We do not reward or pay our doctors or employees for approving or denying services. All decisions are based on appropriate care and coverage.

What we review:

- Medical services
- Medical and surgical supplies
- Some drugs
- Other services

Why we review:

- To determine if services will be covered on your plan
- To determine if services are medically necessary
- To determine if services will be provided in the most clinically appropriate and cost-effective manner

This information may seem complicated, but this section breaks it down for you. We use the following methods for utilization management:

- Prior authorization
- Utilization Review Program
  - Prospective utilization review
  - Concurrent utilization review
  - Retrospective utilization review
- Adverse determination notices
- Review criteria

Have questions about utilization management? Call 1-877-687-1182 (TTY/TDD 1-800-743-3333) to get answers.

What Is Prior Authorization?

Sometimes, we need to approve medical services before you receive them. This process is known as prior authorization. Prior authorization means that we have pre-approved a medical service.

To see if a service requires authorization, check with your primary care provider (PCP), the ordering provider or Member Services. When we receive your prior authorization request, our nurses and doctors will review it. We will let you and your doctor know whether the service is approved or denied.

What Is Utilization Review?

Our Utilization Review Program reviews services to ensure the care you receive will be the best way to help improve your health condition. We have three different utilization review methods:

- Prospective utilization review
- Concurrent utilization review
- Retrospective utilization review

Prospective Utilization Review

Prospective utilization review is a method that reviews and approves services before you receive them. We can perform a prospective utilization review once we have received the necessary information from you.
"Necessary information" includes:

- The results of any face-to-face clinical evaluation (including diagnostic testing)

OR

- Any second opinion that may be required

Once we have determined whether the service will be approved or denied, we will notify you and your provider in writing. If the service or benefit is denied and you don't agree with the decision, you can file an internal appeal (page 39).

Concurrent Utilization Review

Concurrent utilization review is a review method that evaluates your ongoing services or treatment plans (like an inpatient stay or admission) as they happen. This process determines when treatment may no longer be medically necessary. It includes discharge planning to ensure you receive services you need after your discharge.

Retrospective Utilization Review

Retrospective reviews take place after a service has already been authorized. We may perform a retrospective review to:

- Make sure the information provided at the time of authorization was correct and complete
- Evaluate services you received due to special circumstances (for example, if we didn't have time to receive authorization or notification because of an emergency)

!

You aren't financially responsible for any inpatient services you get before receiving your adverse determination notice.

You may be financially responsible for services you get one calendar day or more past the date you received your adverse determination notice.

Adverse Determination and Notices

An adverse determination occurs when a utilization review agent denies a service because it isn't medically necessary, or because it is experimental or investigational.

You will receive written notification to let you know if we have made an adverse determination. When you receive an adverse determination notice depends on the type of review (prospective, concurrent or retrospective).

In your adverse determination notice, you will receive detailed information about why it was issued, as well as the timeframe you should follow for submitting internal appeals.

If you have a life-threatening condition and you receive an adverse determination notice, you will be able to immediately appeal to an independent review organization (IRO). An IRO is a licensed third-party organization that can take another look at your appeal (page 41). If you have a life-threatening condition, you don't have to follow our adverse determination appeal process.

What Are Review Criteria?

Our Utilization Management Committee bases its decisions upon a set of guidelines called review criteria. Criteria are established, evaluated and updated with appropriate involvement from providers who are members of the Utilization Management Committee. This committee makes decisions based on evidence-based medical or healthcare practices and reviews each authorization in an objective manner. Our medical director reviews all potential medical necessity denial decisions.

NOTE:

Our policies ensure that:

- Decisions regarding the delivery of healthcare services are based only on appropriateness of care and services, and the existence of coverage
- Practitioners or other individuals that issue denials of coverage or service care aren't specifically rewarded
- Financial incentives for decision-makers do not encourage decisions that result in underutilization

Want the criteria used to make a specific adverse determination? You (or your treating provider) should contact the medical management department at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Member Complaint And Appeals Process

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We promise that we will never retaliate against you or your provider for filing a grievance or appealing our decision.

If You're Not Happy With Your Care

We hope you will always be happy with us and our providers. But if you aren't, we have steps for handling any problems you may have. To keep you satisfied, we provide the following processes:

- Complaint process
- Complaint submission to the Indiana Department of Insurance (IDOI)
- Appeals process
- External review by an independent review organization (IRO)

How To File A Complaint

You can file a complaint if you aren't happy with your care or a decision we made. To file a complaint, call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333). You will receive a complaint acknowledgment letter within three business days.

Expedited Complaints

If your complaint concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, we will resolve it no later than one business day from the time that we receive it. Within three business days, you will get a letter with the resolution to your complaint.

Non-Expedited Complaints

If you submit a non-expedited complaint, you will get the resolution within 20 calendar days of the time we received it.

Appealing a Complaint

If you aren't satisfied with the resolution to your complaint, you can request an appeal. You must do so within 30 days. If your appeal of your grievance is denied, you have the right to request a review by the IRO. You will receive our final decision within 45 days of your complaint appeal request.

How To File A Complaint (Continued)

Filing with the Indiana Department of Insurance:

You may also file a complaint with the Indiana Department of Insurance (IDOI). There are three ways you may submit a complaint to IDOI. You may file a complaint using our online form or you may print off our form and mail or fax to the Consumer Services Division.

Visit www.in.gov.

1. Mail your complaint to:

   IDOI
   Attn: Consumer Services Division
   311 W. Washington Street, Suite 300
   Indianapolis, IN 46204-2787
2. Fax to: 317-234-2103

View your *Evidence of Coverage* for full complaint and appeal procedures and processes, including specific filing details and timeframes. You can access your *Evidence of Coverage* in your online member account.

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We promise that we will never retaliate against you or your provider for filing a grievance or appealing our decision.

How To File An Appeal

If you have been denied medical or behavioral health services that are medically necessary, you can request an appeal. You must file the appeal within 180 days of receiving the service.

How quickly we answer your appeal depends on the type of appeal you file:

Expedited:

- For life-threatening, urgent or inpatient services
- Response time: one day

Standard:

- For non-emergency services
- Response time: within 30 days

!

If your appeal is denied, you also have the right to request a review by the independent review organization (IRO). Learn more on page 41.

NOTE: You can't request an extension of services after the original authorization has ended. For more details, call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

What Is An Expedited Appeal?

An expedited appeal is an appeal that gets answered quickly. You can request an expedited appeal if you were denied care for an emergency situation or for continued hospital care. We will answer your appeal within one working day from the date we receive all of the necessary information. We will then process your expedited appeal based on the medical condition, procedure or treatment we are reviewing.

You can also request an expedited appeal for an urgent care denial. We will answer your appeal for urgent care within three days of your request. You can request an expedited appeal for urgent care if:

- You think the denial could seriously hurt your life or health
- Your provider thinks that you will experience severe pain without the denied care or treatment
- If you or your doctor feels that you need a service urgently, you can file an expedited appeal for a decision within 48 hours

In order for us to answer an expedited appeal, we have to agree that waiting 30 days for a standard appeal could put your life or health in danger. If we do not agree, we will let you know. Your request will then go through the regular process and you will get an answer in 30 days.

Continued coverage during an appeal

If you file an appeal, your coverage will continue until:

- The end of the approved treatment period

OR

- The determination of the appeal

You may be financially responsible for the continued services if your appeal is not approved.

You can request continued services by calling Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

If you want to ask for an IRO, we can help. Call our appeals coordinator at 1-877-687-1182.

View your *Evidence of Coverage* for full complaint and appeal procedures and processes. You can access your *Evidence of Coverage* in your online member account.

Getting Another Opinion

If we don't approve a service, you have another option for a review. This is known as an independent review organization (IRO), or a third-party reviewer. Doctors who don't work for us make up the IRO.

How to request an IRO if you have a:

- **Life-threatening condition**
  - You can request an IRO without appealing through us first. The IRO will give you their decision within 72 hours. They will also send you a letter for your records within 48 hours of making their decision.
- **Non-life threatening condition**
  - File an appeal with us before requesting an IRO. If we do not answer your appeal in 30 days, you can request an immediate IRO review.

Communication Matters

All of our members are important to us. No matter who you are, we want to make sure we communicate with you the best way that we can. That's why we have communication programs for people who only know a little English or may have sensory impairments. Our members, prospective members, patients, clients and family of members can all use these services.

If you need communication aids or materials related to complaints and appeals, you can get them at no cost. We keep records of each complaint and appeal for 10 years.

Fraud, Waste & Abuse Program

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Report fraud or abuse by calling our FWA Hotline at 1-866-685-8664.

Understanding Insurance Fraud

Insurance fraud is a big deal. We take all cases of fraud and abuse seriously. If you think a provider, member or another person may be committing insurance fraud or abuse, let us know right away. Call our Fraud, Waste and Abuse (FWA) hotline.

FWA Hotline: 1-866-685-8664

An independent third party answers our FWA Hotline. You can call 24 hours a day, seven days a week. And if you don't want to, you don't have to leave your name.

Our staff is also available to talk to you about this. You can contact us at:

Ambetter from MHS
Compliance Department
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

What Is Insurance Fraud?

Insurance fraud occurs when a member, provider or another person misuses our resources. Insurance fraud is any action that defrauds the health plan, for example:

- Loaning, selling or giving your member ID card to someone other than yourself
- Misusing benefits
- Sharing benefits
- Wrongful billing by a provider
- Any action to defraud the program

You receive healthcare benefits based on your eligibility. If you misuse your benefits, you could lose them altogether. Legal action can be taken against you if you misuse your benefits. Providers must report any misuse of benefits to us.

What Is Insurance Abuse?

Abuse is anything that goes against sound financial, business or medical practices, resulting in unnecessary costs. Abuse is accidental — it's not pre-planned and there's no intent to deceive.

Examples include:

- Billing for services that are not covered or medically necessary
- Billing for services that fail to meet professionally recognized standards for healthcare
- Enrollee and provider practices that result in unnecessary costs

Member Rights

Understanding Your Rights

We want to make sure you understand the rights and responsibilities you have as an Ambetter member, legal member guardian or legally authorized surrogate.

For a full list of your specific rights and responsibilities, please see your *Evidence of Coverage*.

Information Rights

You have the right to:

- Request information from your primary care provider (PCP) about what might be wrong (to the level known), treatment and any known likely results
- View your medical records
- Be informed of changes within our network
- Information about our health plans and us
- A current list of our providers
- Select your PCP
- Talk to your provider about new uses of technology
- Information on our quality plan
- Information on how we review new technology
- Have us protect your oral, written or electronic protected health information (PHI)
- Receive information about our organization, its services, its practitioners and providers, and member rights and responsibilities

Respect and Dignity Rights

You have the right to:

- Receive considerate, respectful care at all times
- Receive assistance in a prompt, courteous and responsible manner
- Be treated with dignity when receiving care
- Be free of any harassment from our providers or us (especially if there are any business disagreements between us and a provider)
- Select or switch health plans within the Health Insurance Marketplace guidelines, without any threats or harassment
- Privacy

View a full list of your rights in your *Evidence of Coverage*.

Understanding Your Rights (Continued)

Access Rights

You have the right to care from qualified health professionals. This includes the right to:

- Access treatment or services that are medically necessary, regardless of age, race, creed, sex, sexual preference, national origin or religion
- Access medically necessary emergency services 24 hours a day and seven days a week
- Seek a second medical opinion from an in-network provider, at no cost
- Receive information in a different format in compliance with the Americans with Disabilities Act (if you have a disability)

Informed Consent

It's your healthcare — and you have the right to be involved in it. You, your legal guardians or legal representatives have the right to:

- File an appeal or complaint
- Join in decision-making about your healthcare
- Work on any treatment plans and make care decisions
- Know any possible risks or problems related to recovery and the likelihood of success
- Not receive any treatment without freely giving consent
- Be informed of your care options
- Know who is approving and performing the procedures or treatment
- Receive a clear explanation of the nature of the problem and all likely treatment
- An honest discussion on appropriate clinically or medically necessary treatment options for your condition, regardless of cost or coverage

Complaint/Appeal Rights

You have the right to file an appeal or complaint if you:

- Have had an unsatisfactory experience with us or with any of our in-network providers
- Disagree with certain decisions we have made

External Review Rights

You have the right to apply for an independent external review with the Indiana Department of Insurance (IDOI) if:

- You have been denied services for a life-threatening condition
- We did not resolve an appeal to your satisfaction

Rights and Responsibilities Policies

Your opinion matters. You have the right to make recommendations about our Member Rights and Responsibilities policies.

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We protect all of your PHI.

We follow HIPAA to keep your healthcare information private.

Your Information Is Safe With Us

Your health information is personal. So we do everything we can to protect it. Your privacy is also important to us. We have policies in place to protect your health records.

Protected Health Information (PHI)
PHI is any information about your healthcare. This includes payment information and your health records. We protect all of your oral, written and electronic PHI. Ambetter from MHS employs business practices ensuring physical and technical safeguards are in place, including a state-of-the-art computer security process ensuring our members' information is protected.

Health Insurance Portability and Accessibility (HIPAA)
HIPAA is the law that keeps your healthcare information private. We follow HIPAA requirements and have a Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed, and how you can access this information. We will notify you of these practices every year. Please review your Notice of Privacy Practices carefully. If you need more information or would like the complete notice, visit Ambetter.mhsindiana.com.

Refusal of Treatment
You don't have to receive treatment if you don't want it. You can refuse treatment to the extent that the law allows. However, remember that you are responsible for your actions if you refuse treatment or don't follow your primary care provider's (PCP's) instructions. Talk about all treatment concerns with your PCP — he or she can discuss different treatment plans with you, if there is more than one that may help. The final decision is up to you.

Identity
You have the right to know the name and job title of people who give you care. You also have the right to know which doctor is your PCP.

Language
If you don't speak or understand the language in your area, you have the right to an interpreter.

New Technology
Health technology is always changing, and we want to grow with it. If we think a new medical advancement can benefit our members, we evaluate it for coverage. These advancements include:

- New technology
- New medical procedures
- New drugs
- New devices
- New application of existing technology

Your Information Is Safe With Us (Continued)

Sometimes, our medical director and/or medical management staff will identify technological advances that could benefit our members. The Clinical Policy Committee (CPC) reviews all requests for coverage and decides whether we should change any of our benefits to include the new technology.

If the CPC doesn't review a request for coverage of new technology, our medical director will review the request and make a one-time determination. The CPC will then review the new technology request at their next meeting.

Your Health Records. Your Rights.

At any time, you can ask us for a copy of your personal health records. You have the right to:

- Ask us to give your records only to certain people or groups, and to indicate the reasons for doing so
- Ask us to stop your records from being given to family members or others who are involved in your healthcare (While we will try to follow your wishes, the law may not require us to do so.)
- Ask for confidential communications of your health records. For example, if you think you'd be harmed if we sent your records to your current mailing address, you can ask us to send your health records in another way (like a fax or an alternate address).
- Request behavioral health records. We can only provide this information if we get approval from your treating provider, or from another equally qualified behavioral health professional. We will notify you if we release any medical or behavioral health record information to a medical professional.
- View and get a copy of your designated health record set. This includes anything we use to make decisions about your health, including enrollment, payment, claims processing and medical management records.

In some cases, you won't be able to get access to your health records. If we can't give you a copy of your health records, we will let you know in writing. You can always have our action reviewed. We may not be able to give you:

- Information contained in psychotherapy notes
- Information collected for a court case or another legal proceeding
- Information involving federal laws about biological products and clinical laboratories

If you would like to exercise any of your rights, please contact Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Have questions about how we use or share your health records? Give us a call at 1-877-687-1182 (TTY/TDD 1-800-743-3333). We're available Monday through Friday, 8 a.m. to 5 p.m. EST.

Right To Receive Accounting of Disclosures

You have the right to receive an accounting of disclosures of your health records. This is a list of the times we shared your health records. According to legal guidelines, we don't have to provide:

- Health records given or used for treatment, payment and healthcare operations purposes
- Health records given to you or others with your written approval
- Information related to a use or disclosure that you allowed
- Health records given to people involved in your care or for other notification purposes
- Health records used for national security or intelligence purposes
- Health records given to prisons, the police, the Federal Bureau of Investigation (FBI), health oversight agencies and others who enforce laws
- Health records given or used as part of a limited data set for research, public health or healthcare operations purposes

To receive an accounting of disclosures, send us a request in writing. We will act on your request within 60 days — and if we need more time, we may take up to another 30 days.

Your first accounting of disclosures list will be free. You can get a free list every 12 months. If you ask for another list within 12 months, we may charge you a fee. But don't worry — we will let you know about the fee in advance and you'll have the chance to take back your request.

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Call 1-877-687-1182 (TTY/TDD 1-800-743-3333) if you need help exercising your rights.

How To Use Your Rights

We want you to be happy as our member. That includes knowing and understanding your rights at all times. Remember, you have the right to receive a copy of this member handbook.

We may change or update our policies at any time. If we do, these changes will apply to all of our health records. Whenever we make changes, we will send a new notice to you.

If you feel like your rights have been violated, contact:

Ambetter from MHS
Privacy Officer
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

Phone: 1-877-687-1182
TTY/TDD 1-800-743-3333
Fax: 1-877-941-8072

You can also contact the Secretary of the United States Department of Health and Human Services (HHS):

Office for Civil Rights – Region V
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697
Fax: 1-312-886-1807

If you file a privacy complaint, we promise that we will not take any action against you, your physician, provider or anyone else acting your behalf.

Member Responsibilities

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For more information about your member responsibilities, read your *Evidence of Coverage*.

Here's What You Should Do

Your *Evidence of Coverage* can help you understand how your plan works. Make sure you read it. Here are a couple of key points:

Giving Information
Always provide accurate and complete information about your health. This includes your present conditions, past illnesses, hospitalizations, medications and any other matters. Let us know that you clearly understand your care and what you need to do. Ask your doctor questions until you understand the care you are receiving. You need to review and understand the information you receive about us. Make sure you know how to use the services we cover.

Your Doctor's Advice and Your Treatment Plan
You should follow the treatment plan your medical providers suggest. Ask questions to make sure that you fully understand your health problems and treatment plan. Work with your primary care provider (PCP) to develop treatment goals. If you don't follow your treatment plan, your doctors may tell you the likely results of your decision.

Member ID Card
At every appointment, always show your Ambetter member ID card before you receive care.

Emergency Room Use
Only use an emergency room (ER) when you think you have a medical emergency. For all other care, you should call your PCP.

Appointments
Make sure you keep your appointments. If you cannot keep an appointment, you should call to cancel or reschedule. Whenever possible, schedule your appointments during office hours.

Your PCP
You should know the name of your PCP and establish a relationship with him/her. At any time, you can change your PCP by contacting our Member Services Department at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Treatment
You should treat all of our staff, providers and other members with respect and dignity. If you have concerns about your care, please let us know in a useful manner.

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For more information about your member responsibilities, read your *Evidence of Coverage*.

Here's What You Should Do (Continued)

Changes

Let us know if you have any changes to your address, name, telephone number or family. You will also need to update your information on the Health Insurance Marketplace. Call us at 1-877-687-1182 (TTY/TDD 1-800-743-3333) or visit the Health Insurance Marketplace at www.healthcare.gov.

Other Medical Insurance

When you enroll in a plan with us, you need to give us all of the information about any other medical insurance coverage you have or will receive. You also need to tell the Health Insurance Marketplace.

Costs

If you access care without following our rules, you may be responsible for the charges. Depending on your plan, you may also be responsible for paying your portion of the monthly premium and all copayments when you receive a service.

Advance Directives

All of our adult members have the right to make advance directives for healthcare decisions. Advance directives are forms you can complete to protect your rights for medical care in end-of-life situations. They can help your primary care provider (PCP) and other providers understand your wishes about your health. Advance directives will not take away your right to make your own decisions. They will work only when you are unable to speak for yourself.

Examples of advance directives include:

- Living will
- Healthcare power of attorney
- "Do Not Resuscitate" (DNR) orders

If you don't have an advance directive, we won't hold it against you. For more information about advance directives, as well as a form you can use to designate a healthcare proxy, please call Member Services at 1-877-687-1182 (TTY/TDD 1-800-743-3333).

Words To Know

Your Healthcare Glossary

We know that health insurance can feel confusing sometimes. To help you out, we put together a list of words you may need to know as you read through this member handbook. Check it out!

Adverse Determination Notice
This is the notice you receive if we deny coverage for a service you have requested.

Eligibility
As an Ambetter member, you are eligible for coverage through the Health Insurance Marketplace.

Emergency Care/Emergencies
Emergency care is care that you receive in an emergency room (ER). Only go to the ER if your life is at risk and you need immediate, emergency medical attention.

Evidence of Coverage
The document that lists all of the services and benefits that your particular plan covers. Your *Evidence of Coverage* has information about your specific copayment, cost sharing and deductible amounts. Read through your *Evidence of Coverage* — it can help you understand exactly what your plan does and doesn't cover.

Grievance/Appeal
If you are denied a service, you can submit a grievance or appeal. These are formal complaints that let us know you would like us to take another look at our decision to not cover a service.

In-Network (Providers and/or Services)
The Ambetter network is the group of providers and hospitals we partner with to provide care for you. If something is in our network, it is covered on your health insurance plan. If something is out of network, you will probably have to pay extra for services you receive. When possible, always stay in network!

Your Healthcare Glossary (Continued)

Premium Payment
Your premium is the amount of money you'll pay every month for health insurance coverage. Your monthly bill shows your premium payment.

Preventive Care Services
Preventive care services are regular healthcare services designed to keep you healthy and catch problems before they start. For example: your checkups, blood pressure tests, certain cancer screenings and more.

Primary Care Provider (PCP)
Your PCP is the main doctor you will see for your healthcare needs. Get to know your PCP well and always stay up-to-date with your well-visits. The better your PCP knows your health, the better he/she is able to serve you.

Prior Authorization
Prior authorization may be required for covered services. When a service requires prior authorization, then the covered service needs to be approved before you visit your provider. If something requires prior authorization, you will need to check with your PCP or Member Services. You will need to submit a prior authorization request.

Schedule of Benefits
Your *Schedule of Benefits* is a document that lists covered benefits available to you and lets you know when you are eligible to receive them.

Subsidy
A subsidy is a tax credit that lowers your monthly premium. Subsidies come from the government. Whether or not you qualify for one depends on your family size, your income and where you live.

Urgent Care
Urgent care is for a condition that needs treatment within the next 24 hours but is not life-threatening.

Utilization Management
This is the process we go through to make sure you get the right treatment. We review your medical and health circumstances and then decide the best course of action.

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