Important Information from Ohio Department of Medicaid for New Members

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

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

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

Please let us know …

If you have a problem reading or understanding this information or any other Paramount Advantage information, please contact our member services at 1-800-462-3589, TTY users 1-888-740-5670 for help at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.
Paramount Advantage remains committed to the members we are honored to serve.

This Paramount Advantage Member Handbook was created with the guidance and support of members, who participated in our Family Advisory Councils in Allen, Cuyahoga and Muskingum County throughout 2014.

On behalf of everyone at Paramount Advantage, a sincerest thanks to our Family Advisory Council members for their time and talents in helping to creating our Member Handbook. We hope you find the information contained in this handbook, very helpful.

Thank you!
### Keep These Numbers Handy

<table>
<thead>
<tr>
<th>Primary Care Provider (PCP/Doctor)</th>
<th>Pediatrician</th>
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<th>Urgent Care</th>
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<th>Dentist</th>
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<tr>
<th>Member Services Department</th>
<th>Paramount’s 24-hour Nurse Line</th>
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<tr>
<td>Answer questions and solve complaints promptly</td>
<td>The ProMedica Call Center</td>
</tr>
<tr>
<td>1-800-462-3589 (TTY users 1-888-740-5670)</td>
<td>1-800-234-8773 (TTY users 1-800-750-0750)</td>
</tr>
<tr>
<td>Monday - Friday 7:00 a.m. - 7:00 p.m.</td>
<td>24 hours a day, 7 days a week</td>
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<th>Prenatal to Cradle</th>
<th>Transportation Scheduling &amp; Pick-up</th>
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<tr>
<td>Pregnancy Rewards Program</td>
<td>Must schedule at least 2 business days in advance</td>
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<tr>
<td>1-888-296-0220 (TTY users 1-888-740-5670)</td>
<td>1-866-837-9817 (TTY users 1-800-750-0750)</td>
</tr>
<tr>
<td>Monday - Friday 8:30 a.m. - 5:00 p.m.</td>
<td>Monday - Friday 8:30 a.m. - 5:00 p.m.</td>
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<tr>
<th>Ohio Medicaid Hotline</th>
<th>Mobile Website</th>
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<td>1-800-324-8680 (TTY users 1-800-292-3572)</td>
<td><a href="http://www.ParamountAdvantage.org">www.ParamountAdvantage.org</a></td>
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</tbody>
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### Member Services Department Can Take Care Of...

- Questions about covered benefits and services
- Name, address and phone number changes
- Changing your primary care provider (PCP)
- Finding a new provider, specialist, dentist, or eye doctor
- Questions about services not listed in the chapter “What is covered?”
- Adding your newborn and getting his/her Member ID Card
- Sending you a replacement Member ID Card
- Pre-authorization, pharmacy, and durable medical equipment questions
- Interpreter Services
Welcome to Paramount Advantage™

What is Paramount Advantage?

Welcome to Paramount Advantage, an affiliate of ProMedica. You are now a member of a healthcare plan also known as a managed care plan (MCP). Paramount Advantage provides health care services to Ohio residents eligible for Aged, Blind or Disabled and Covered Families and Children, including Healthy Start and Healthy Families and Adult Extension, Medicaid benefits.

Paramount Advantage is pleased to provide you with access to quality healthcare services. Call our Member Services Department any time you have questions about healthcare services.

You can contact Paramount Advantage to get any other information you want, including the structure and operation of Paramount Advantage and how we pay our providers.

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

Who can join Paramount Advantage?

Aged, Blind or Disabled and Covered Families and Children Medicaid consumers in Ohio, including Healthy Start and Healthy Families and Adult Extension, can choose to join.

It is important to remember that you must receive services covered by Paramount Advantage from facilities and/or providers on Paramount Advantage’s panel. See page 13 for information on services covered by Paramount Advantage. The only time you can use providers that are not on Paramount Advantage’s panel is for:

- Emergency services,
- Federally qualified health centers/rural health clinics,
- Qualified family planning providers,
- Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health centers and treatment centers, or
- An out-of-panel provider that Paramount Advantage has approved you to see

What you must do to receive benefits

Paramount Advantage will pay healthcare costs if you follow four guidelines:

1. You see your primary care provider (PCP).
2. You get Paramount Advantage approval to see out-of-plan providers with the exception of emergency care, federally qualified health centers/rural health clinics and qualified family planning providers in your Provider Directory.
3. You use the emergency room appropriately. (See page 11 for an explanation of emergency care.)
4. You follow the rules outlined in this Member Handbook.

If you follow the guidelines above, you should not receive any bills. If you do get bills, call the Member Services Department.
New members who need ongoing care.

It is important for any new members who have a health condition that requires ongoing care to call our Member Services Department as soon as possible. For example, if you need surgery, are pregnant, have asthma or diabetes, are receiving speech or physical therapy, have braces, or are receiving home health services (e.g., aides and private duty nursing), you need to call Member Services. We want to make sure that your care continues smoothly, without interruption, while you change over to Paramount Advantage.

Calling the Member Services Department

The Member Services Department will help you right away.

Paramount Advantage’s Member Services Department can help you with any questions or issues you may have, such as what services are covered, how to access services, help finding a provider, filing a complaint about the MCP/providers/discrimination, changing your PCP, and accessing language assistance. If your primary language is not English, are visually or hearing impaired, or have limited reading skills, please call us to arrange interpreter services.

You should be satisfied with all aspects of the service you receive. If you have questions or recommendations for change, the Member Services Department is thoroughly trained and ready to help you.

The Member Services Department can be reached at toll-free 1-800-462-3589, TTY users 1-888-740-5670. The Member Services Department is available Monday – Friday, 7:00 a.m. – 7:00 p.m. (except on holidays).

Paramount Advantage is closed on New Year’s Day, Memorial Day, Independence Day (July 4), Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day. If the Paramount-recognized holiday occurs on a Saturday, the Member Services Department will be closed on the preceding Friday. If the Paramount-recognized holiday occurs on a Sunday, the Member Services Department will be closed on the following Monday.

If you want to tell us about things you think we should change, please call the Member Services Department at toll-free 1-800-462-3589, TTY users 1-888-740-5670.

24 Hour Nurse Line, the ProMedica Call Center.

If you need medical advice, the ProMedica Call Center is a special service available 24 hours every day with general information plus a staff of nurses to assist you. The ProMedica Call Center telephone number is toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750.
Your Paramount Advantage Identification Card

You should have received a Paramount Advantage membership ID card. Each member of your family who has joined Paramount Advantage will receive his or her own card. Your ID card replaces the monthly Medicaid card. Each card is good for as long as the person is a member of Paramount Advantage. You will not receive a new card each month as you did with the Medicaid card.

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 Paramount Advantage ID card when you:

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

Call Paramount Advantage Member Services as soon as possible at toll-free 1-800-462-3589, TTY users 1-888-740-5670 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 new baby

EMERGENCY SERVICES
Call 911 or go to the nearest emergency room (ER). If you are not sure whether you need to go to the emergency room, call your primary care provider (PCP) or Paramount’s 24-hour toll-free call-in-system (ProMedica Call Center) toll free at 1-800-234-8773 or the Ohio Relay Service TTY at 1-800-750-0750.

SPECIALTY SERVICES
Before seeing a specialist, you should always first contact your PCP as indicated in your member handbook.

HOSPITAL ADMISSIONS
Prior authorization must be obtained by the hospital prior to all non-emergency admissions.

MEMBER SERVICES
For eligibility, claims or benefit information call MEMBER SERVICES toll free at: 1-800-462-3589, TTY 1-888-740-5670, Monday - Friday 7:00 a.m. - 7:00 p.m.

If for any reason you need to change your PCP, call MEMBER SERVICES first so that you can begin using that new PCP immediately.
How to let Paramount Advantage know if you are unhappy or do not agree with a decision we made.

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

To contact us you can:

- Call the Member Services Department at 1-800-462-3589, TTY users 1-888-740-5670, OR
- Fill out the form in your Member Handbook (page 24) Grievance Form, OR
- Call the Member Services Department to request they mail you a form, OR
- Visit our website at www.ParamountAdvantage.org, OR
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your Paramount Advantage member ID card, and your address and telephone number in the letter so that we can contact you if needed. You should also send any information that helps explain your problem. (See address on page 33).

Other health insurance (coordination of benefits – COB).

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

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

Some examples of when emergency services are needed include:

- Broken bones
- Convulsions
- Difficult breathing
- Hallucinations or delusions; uncontrollable thoughts
- Miscarriage/pregnancy with vaginal bleeding
- Poisoning
- Severe bleeding
- Severe burns
- Severe pain in the stomach or chest areas
- Shock
- Thoughts of harming self or others; behavior dangerous to self or others
- Unconsciousness
- Vomiting blood

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

If you are not sure whether you need to go to the emergency room, call your primary care provider (PCP) or Paramount Advantage’s 24-hour medical information service, the ProMedica Call Center, at toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750. Your PCP or the ProMedica Call Center can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

1. Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of Paramount Advantage and show them your ID card.

2. If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call Paramount Advantage.

3. Contact your PCP or call the Member Services Department as soon as possible. Try to call within 48 hours after going to the emergency department.

4. If the hospital has you stay, please make sure that Paramount Advantage is called within 48 hours.

5. Schedule an appointment with your PCP for all follow-up services.

If you are out of town.

If you need non-emergency care when you are outside the county in Ohio where you live, you are covered.

First, call your PCP or Paramount Advantage’s 24-hour medical information service, the ProMedica Call Center at toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750. If that is not possible, seek
treatment at the nearest medical facility or at a Paramount Advantage participating doctor’s office and call the Member Services Department within 48 hours.

Schedule an appointment with your PCP for all follow-up services.

Urgent Care Centers

Using an Urgent Care Center.

If you have a medical problem arise that you don’t think is an emergency, you should call your PCP or visit a participating Urgent Care Center to prevent the injury or illness from getting worse.

You can also call Paramount Advantage’s 24-hour medical information service, the ProMedica Call Center, for advice and instructions on what to do to help ease the illness or injury at **toll-free 1-800-234-8773**, or the Ohio Relay Service TTY toll-free 1-800-750-0750.

Participating Urgent Care Centers are listed in your Provider Directory or online at [www.ParamountAdvantage.org](http://www.ParamountAdvantage.org).

Going to the Hospital

Use a participating hospital.

You must use participating Paramount Advantage hospitals unless it is an emergency or you have received approval to use an out-of-state hospital for non-emergency care. Paramount Advantage offers you a choice of hospitals. Ask your PCP for names of hospitals where she/he is on staff.

All elective inpatient admissions require prior authorization.

If you are admitted to a hospital for an emergency when you are away from home or out of state, someone must notify your PCP or the Member Services Department within 48 hours or as soon as reasonably possible. You must see your PCP for all follow-up care.

24 Hour Nurse Line, the ProMedica Call Center.

If you need medical advice, the ProMedica Call Center is a special service available 24 hours every day with general information plus a staff of nurses to assist you. The ProMedica Call Center telephone number is **toll-free 1-800-234-8773**, or the Ohio Relay Service TTY toll-free 1-800-750-0750.
YOUR DOCTOR

Your Doctor Is Your Healthcare Partner

Provider panel / Provider directory.

The Provider Directory lists all of our panel providers as well as other non-panel providers you can use to receive services. When you called the Medicaid Hotline to select a managed care plan (MCP), you were asked whether you wanted provider panel information given to you as a printed Provider Directory or via the Internet. If you asked for a printed directory, you should have received a Provider Directory. If you did not contact the Medicaid Hotline to enroll and were assigned to our plan, you may call Member Services to obtain a printed Provider Directory. The Provider Directory is available online and continuously updated. Visit our website at www.ParamountAdvantage.org to view up-to-date provider panel, pharmacy, and urgent care information.

Choosing a Primary Care Provider. (PCP).

Each member of Paramount Advantage must choose a primary care provider (PCP) from Paramount Advantage’s Provider Directory. Your PCP is an individual physician, physician group practice, advanced practice nurse or advanced practice nurse group practice trained in family medicine (general practice), internal medicine, or pediatrics. Your PCP is your personal doctor.

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

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

If you need non-emergency care after hours, call your PCP for instructions, or you can call Paramount Advantage’s 24-hour medical information service, the ProMedica Call Center at toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750.

When should you visit your PCP?

You should visit your primary care provider (PCP) for regular Healthchek exams, adult well exams and when you are ill. Although you do not need a PCP referral to see other providers, it is still important to contact your PCP before you see a specialist, have lab tests done or are admitted to the hospital (except in an emergency).

You do not need to contact your PCP before making appointments with obstetricians, gynecologists, certified nurse-midwives, certified nurse practitioners, federally qualified health center/rural health clinic providers, family planning providers, and providers at MHAS certified community mental health centers or certified treatment centers. However, you may still want to discuss this treatment with your PCP.
Your PCP is responsible for managing your care, which is a feature of an MCP like Paramount Advantage. If you would like information about how Paramount providers are paid, call the Member Services Department.

**Changing your PCP.**

If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. Members can change PCPs on a monthly basis. Paramount Advantage will send you a new ID card to let you know that your PCP has been changed and you can begin seeing your new PCP immediately.

For the names of the PCPs in Paramount Advantage, you may look in your Provider Directory if you requested a printed copy, on our website at www.ParamountAdvantage.org, or you can call the Paramount Advantage Member Services Department at **toll-free 1-800-462-3589, TTY users 1-888-740-5670** for help.

**Healthchek.**

Healthchek is Ohio’s early and periodic screening, diagnostic and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21 years. These exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams, and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

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

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

- Preventive check-ups for newborns, infants, children, teens, and young adults under the age of 21.

- Healthchek screenings:
  - Complete medical exams (with a review of physical and mental health development)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing
As a part of Healthchek, care management services are available to all members under the age of 21 years who have special healthcare needs. Please see page 29 to learn more about the care management services offered by Paramount Advantage.

If you would like more information on the Healthchek program, please contact the Member Services Department at toll-free 1-800-462-3589, TTY users 1-888-740-5670. Member Services can also help you with and answer questions about getting care and what services are covered, finding a provider/making an appointment, prior authorizations, or transportation assistance.

You can call your PCP and dentist to make an appointment for regular check-ups and ask for a Healthchek exam when you call.

- Laboratory tests for certain ages
- Immunizations

- Medically necessary follow-up care to treat physical, mental or other health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - Visits with a primary care provider, specialist, dentist, optometrist, and other Paramount Advantage providers to diagnose and treat problems or issues
  - Inpatient or outpatient hospital care
  - Clinic visits
  - Prescription drugs
  - Laboratory tests
  - Health education

It is very important to get preventive check-ups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Some services may require a referral from your PCP or prior authorization by Paramount Advantage.

Also, for some EPSDT items or services, your provider may request prior authorization for Paramount Advantage to cover things that have limits or are not covered for members over age 20. Please see pages 24-25 to see what services require a referral and/or prior authorization.
Women’s Health and Pregnancy Care

Family planning services.

Family planning is available through your Primary Care Provider (PCP), Obstetrician (OB) or Gynecologist (Gyn), certified nurse-midwife, or at a qualified Medicaid family planning provider including your local health department, Federally Qualified Health Centers, Planned Parenthood, or rural clinics. You do not need a referral from your PCP. Simply pick a family planning provider from the list in the Provider Directory and make an appointment.

OB or GYN care.

Female Paramount Advantage members can see an in-network Primary Care Provider (PCP), Obstetrician (OB) or Gynecologist (Gyn), Certified Nurse Midwife for female health care. The OB or Gyn or certified nurse-midwife may refer you to another specialist based on your medical needs. If your health issue is not related to an OB/GYN condition, you should ask your PCP about seeing a specialist.

Please call our Member Services Department for the following reasons:

- If you become a Paramount Advantage member in your third trimester of pregnancy
- You need help finding an OB/GYN or Certified Nurse Midwife, Pediatrician, or a PCP
- When your baby is born. Member Services will need the baby’s name, date of birth, and pediatrician so we can mail a Paramount Advantage membership card for your newborn.
- You have questions or concerns about Paramount Advantage benefits or services

* Remember to also contact Jobs & Family Services office to tell them you are pregnant and again after you deliver to have your newborn added to your case.

Prenatal care guidelines.

Paramount Advantage wants you and your baby to have a healthy start. Your first OB/GYN or Certified Nurse Midwife appointment will include a health risk assessment. Your OB/GYN or Certified Nurse Midwife will talk to you about your pregnancy history and your current health.
Follow-up appointments are usually scheduled every 4 weeks for the first 28 weeks of your pregnancy, every 2 weeks through 36 weeks of your pregnancy and weekly through your last month of pregnancy. Your follow-up appointments will be scheduled based on the personal needs and health risks of your pregnancy.

If your pregnancy is considered high-risk or you or your newborn have serious health complications, you may qualify for Case Management. Case Management is a program where licensed case managers work with doctors and medical providers to coordinate health care for our members. Case managers can teach you ways to play a bigger role in your health care. For more information on care management services, please call Member Services.

**Postpartum care guidelines.**

A postpartum (after delivery) appointment should be scheduled **21-56 days after your delivery date.** Your OB/GYN or Certified Nurse Midwife may want to see you within 7-14 days of delivery after a cesarean delivery or a complicated pregnancy but please also schedule a 3-8 weeks (21-56 days) after delivery postpartum appointment.

A **postpartum visit** on or between 21 and 56 days after delivery should consist of:

- Pelvic exam
- Evaluation of weight, blood pressure, breasts, and abdomen
- Family planning and birth control discussion

Paramount Advantage members get two postpartum home health visits by a nurse or home healthcare provider. Please take advantage of this member benefit as a chance to get medical care without having to leave your house so you have more time to adjust to life with your newborn. This home health visit is to help with any medical questions or concern you have after first coming home from the hospital. You will still need to schedule a postpartum appointment with your OB/GYN or Certified Nurse Midwife 3-8 weeks (21-56 days) after delivery.

**Postpartum Depression also known as the “baby blues.”**

1 in 7 moms experience depression or anxiety during pregnancy or postpartum. You are not alone. A Postpartum Depression Survey is mailed to moms 2 weeks after delivery. New moms will also receive a letter explaining postpartum depression. Members are asked to: 1) complete the survey, 2) mail it back to Paramount Advantage and 3) call their OB/GYN or Certified Nurse Midwife provider for additional services if they score 11 points or higher on the survey.

**Breast Pumps & Lactation/Breastfeeding Classes.**

Breast pumps are covered by Paramount Advantage. Breast pumps are considered Durable Medical Equipment (DME) so they require a prescription from your OB/GYN or Certified Nurse Midwife. You can order a breast pump from any network DME provider. Please contact our Member Services toll-free 1-800-462-3589, TTY users 1-888-740-5670 to learn how to order a breast pump or for a network DME provider near you.
For information on breastfeeding and lactation/breastfeeding classes, please contact your local WIC office, your OB/GYN or Certified Nurse Midwife, or the hospital you will be delivering at.

For information on childbirth and infant care classes, please contact the hospital you will be delivering at.

**Primary Care Provider (PCP) and Infant Immunizations (shots).**

It is important that both you and your newborn have a Primary Care Provider (PCP). Healthchek and pro-active health services are offered to all Paramount Advantage members at no cost. For your best health, you should get regular care through their PCP before and after pregnancy. During pregnancy, you should see your OB/GYN or Certified Nurse Midwife for early and regular prenatal care and postpartum wellness.

Children should have well-check exams with their PCP at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24 (2 years old), and 30 (2 ½ years old) months of age. After age 2 ½, children should have at least one well-check per year. See HealthChek Guidelines on Page 14 for full details.

**Prenatal to Cradle Program.**

Members can earn up to $125 in gift cards for completing the recommended number of prenatal/postpartum visits. Contact Paramount Advantage Member Services Department for more information or register online at www.ParamountAdvantage.org.

**Text4baby.**

Text4baby is a free text message health service for pregnant women and new moms and dads. Sign up online at www.ParamountAdvantage.org to receive up to three text messages (health tips) a week, timed to your due date or your baby's birth date through the baby's first year. Text messages include helpful information on how to have a healthier pregnancy, nutrition, immunizations, and sleep safety.
Are You PREGNANT or Thinking About Having a Baby?

As soon as you find out you are pregnant... Get early and regular prenatal care!

Important changes are happening to your baby very early in pregnancy; sometimes before a woman even knows they are pregnant.

All appointments are very important to attend!

OB/GYN or Certified Nurse Midwife Appointments.

- Your OB/GYN or Certified Nurse Midwife may order numerous important lab tests throughout your pregnancy
- Talk honestly about your family health history and the health history of your baby's father
- Talk about ALL the over-the-counter/prescription medicines and herbal supplements you take
- Prenatal-Postpartum Appointment Schedule

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Appointment Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>First 28 weeks</td>
<td>Every 4 weeks</td>
</tr>
<tr>
<td>Weeks 29-36</td>
<td>Every 2 weeks</td>
</tr>
<tr>
<td>Last 4 weeks</td>
<td>Once a week</td>
</tr>
<tr>
<td>21-56 days after delivery</td>
<td>Once, although may have more than one postpartum visit</td>
</tr>
</tbody>
</table>

These appointments may vary as your OB/GYN or Certified Nurse Midwife may want to see you more often or have you do more tests.

ASK QUESTIONS about your Growing Baby During Pregnancy.

- Ask what level of activity is safe for you and baby
- Ask about the benefits of breastfeeding
- Learn more about what you should expect and what you need to do during this pregnancy
- Ask about signs and symptoms you should report to our OB/GYN or Certified Nurse Midwife
- Ask about baby activity and monitoring fetal kick count

During your PREGNANCY & while BREASTFEEDING.

- DO NOT DRINK ALCOHOL – No amount of alcohol is safe for the unborn baby
- DO NOT SMOKE OR USE ILLEGAL DRUGS – if you smoke or use illegal drugs Paramount Advantage offers programs to help, please call Member Services today
- Avoid second hand smoke and other toxic or harmful substances
- Take your prenatal vitamin, folic acid, and multivitamin everyday
- Drink plenty of water, limit caffeine, and eat a variety of whole grains, vegetables and fruits and make sure meat, eggs, chicken/turkey and fish are fully cooked – limit the amount of canned tuna and fish caught in local waters
Are You Trying Not to have a Baby?

- Being healthy will help your chance of having a healthier baby when you decide it’s time
- More than half of all pregnancies are not planned, discuss with your PCP or OB/GYN about your birth control options
- Get regular wellness exams with your PCP and make sure you are up to date on your shots
- Have regular dental check-ups
- Have regular gynecological exams
- Learn how to protect yourself from sexually transmitted infections
- Drink plenty of water, avoid caffeine. Eat a variety of whole grains, vegetables and fruits, and make sure meat, eggs, chicken/turkey and fish are fully cooked
- Do not smoke or use illegal drugs
- Avoid second hand smoke and other toxic or harmful substances
- Get regular exercise
- Plan to wait at least 18 months between your pregnancies

NEW MOMS

Talk with your doctor about:

- Scheduling a postpartum checkup 21-56 days after delivery
- Feelings of stress or sadness that does not go away
- When it’s safe to go back to your regular activities

Remember:

- Make sure baby has a safe place to sleep – **Alone, on their Back face up, in a Crib free** of stuffed animals, blankets, pillows, bumpers, and toys
- Give yourself time to rest when baby is resting
- Ask family and friends for help
- Make sure your baby gets shots on time
- Eat a variety of vegetables, fruits, meats, and whole grains
- Continue taking folic acid and a multivitamin
- Plan to wait at least 18 months between your pregnancies

Need transportation to appointments?
Your newborn will have transportation benefits starting at birth. Call 866-837-9817 to schedule a ride. (See pages 27-28 for full details).

Have you joined the Prenatal to Cradle Pregnancy Rewards program? (See page 27 for full details).

Other Questions?
Call Member Services toll-free 800-462-3589, TTY users 888-740-5670.
**SERVICES COVERED**

### Filling Prescriptions

**Using a participating pharmacy.**

Prescriptions from your physician can be filled at any participating pharmacy. There are numerous participating pharmacies. A list of these pharmacies may be found in the Provider Directory and online at [www.ParamountAdvantage.org](http://www.ParamountAdvantage.org). If you have questions, contact the Member Services Department.

When you go to the pharmacy, show your Paramount Advantage card to the pharmacist.

Generic drugs, approved by the U.S. Food and Drug Administration, will be used to fill your prescription unless the provider specifies a brand or trade-name brand which is covered by Medicaid and authorized by Paramount Advantage. Generic drugs have the same basic ingredients as trade-name drugs but may look different. Using the generic drug when it is available helps to keep healthcare costs down.

**Prescription drugs.**

While Paramount Advantage covers all medically necessary Medicaid-covered medications, we use a preferred drug list (PDL). These are the drugs that we prefer that your provider prescribe. We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior-authorize a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first.

Some drugs may also have quantity (amount) limits and some drugs are never covered, such as drugs for weight loss.
If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing.

You can call Member Services to request information on our PDL and medications that require prior authorization. You can also look on our website at www.ParamountAdvantage.org. Please note that our PDL and list of medications that require prior authorization can change, so it is important for you and/or your provider to check this information when you need to fill/refill a medication.

Your healthcare provider can order over-the-counter medications.

Paramount Advantage will also pay for many over-the-counter medicines, including but not limited to the medicines to treat coughs, allergies or fevers, if your healthcare provider writes a valid prescription. Be sure to fill all prescriptions at a participating pharmacy. You can find participating pharmacies in our Provider Directory or on our website at www.ParamountAdvantage.org.

Durable Medical Equipment (DME).

Durable Medical Equipment (DME) – DME items such as Breastfeeding Pump, Insulin Pumps, Blood Pressure Monitor, Nebulizers, Walkers, and Wheelchairs may be prescribed by your provider. Those prescriptions must be filled at special DME network providers, as payment for these items will be denied at your normal pharmacy. To find a DME network provider, please call Member Services.

Restrictions on choice of providers.

When you join Paramount Advantage, it is important to remember that you must receive all medically necessary healthcare services from Paramount Advantage facilities and/or providers. The only time you can use providers that are not on Paramount Advantage’s panel is for emergency services, federally qualified health centers/rural health clinics, qualified family planning providers, MHAS certified community mental health centers or certified

Coordinated Services Program

The State of Ohio permits MCPs to develop and implement programs to assist certain members who have received drugs that are not medically necessary to establish and maintain a relationship with one provider and/or pharmacy to coordinate treatment. Members selected for Paramount Advantage’s program will be provided additional information and notified of their state hearing rights, as applicable.

A member may be enrolled in the Coordinated Services Program, or CSP, if a review of his/her utilization demonstrates a pattern of receiving services at a frequency or in an amount that exceeds medical necessity. CSP enrollees must get medications filled at one pharmacy and coordinate medical services through their primary care provider.

Enrollees can request to change their pharmacy and/or PCP if the assigned pharmacy or provider is no longer accessible. Paramount Advantage will give enrollees approval to use a different pharmacy if they have a pharmacy emergency. Selected members enrolled in the CSP will receive additional information and be notified of their right to a state hearing.
treatment centers which are Medicaid providers, and an out-of-panel provider that Paramount Advantage has approved you to see.

If you have questions about Veteran Benefits or Paramount Advantage facilities and providers, call the Member Services Department.

What is covered?

Paramount Advantage gives you all the benefits you received with your Medicaid health card, with an emphasis on preventive services and personalized care to keep you healthy.

Services covered by Paramount Advantage.

As a Paramount Advantage member, you will continue to receive all medically-necessary Medicaid-covered services at no cost to you.

- Primary care providers (PCP) services. (See page 13.)
- Yearly well-adult exams (provided by PCP).
- Well-child (Healthchek) exams for children under the age of 21 (provided by PCP).
- Shots (immunizations).
- Preventive mammogram (breast) and cervical cancer (Pap smear) exams.
- Preventive bone density exam.
- Preventive colorectal cancer exam.
- Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source.
- Free-standing birth center services at a free-standing birth center. Members should call member services to see if there are any qualified centers in Ohio.
- Nursing Facility Services call member services for information on available providers.
- Respite services which are for SSI members under 21 years of age. These services provide short-term, temporary relief to an informal, unpaid caregiver in order to support and preserve the primary caregiving relationship. For more information on respite services, please contact Member Services at toll-free 1-800-462-3589, TTY users 1-888-740-5670.
The following services require a prescription from your doctor or prior authorization:

- Diagnostic services (X-ray, lab) (Requires a prescription and some may require prior authorization.)
- Speech and hearing services, including hearing aids (Requires a prescription and, for speech therapy services beyond benefit limits, prior authorization is required.)
- Physical and occupational therapy (Requires a prescription and, for therapy services beyond benefit limits, prior authorization is required.)
- Developmental therapy services for children aged birth to six years (Requires a prescription and, for therapy services beyond benefit limits, prior authorization is required.)
- Outpatient hospital services (Requires a prescription or some may require prior authorization.)
- Inpatient hospital services (Requires prior authorization, except in an emergency.)
- Prescription drugs, including certain prescribed over-the-counter drugs (Some may require prior authorization or step therapy.) (See page 21.)
- Medical supplies (Requires a prescription.)
- Durable medical equipment (DME) (Requires a prescription and some may require prior authorization.)
- Ambulance and ambulette transportation (Requires prior authorization, except in an emergency.)
- Podiatry (foot) services (Some may require prior authorization.)
- Home health services (Requires prior authorization.)
- Hospice care (care for terminally ill; e.g., cancer patients) (Requires prior authorization.)
- Renal dialysis (kidney disease) (If directed by your PCP or kidney specialist to a participating provider, no referral is needed.)

Some services may require prior authorization from Paramount Advantage before you receive them. When your doctor recommends certain forms of treatment, he/she is responsible for obtaining authorization from Paramount Advantage.

Prior Authorization – A process of receiving prior approval from Paramount Advantage before receiving certain services. The review process occurs between Paramount Advantage providers and the Utilization Review Department and is performed by phone, fax or web-based tool. Paramount Advantage will make the decision within two working days. An approval notice will be sent to you within three workings days of the decision. If the decision is a denial, the notice will be mailed to you at the same time the decision is made. Decisions are made quicker if your condition is such that you cannot wait two working days for a decision to receive the service. Requests for drugs administered in a provider setting or obtained at a pharmacy will be decided in 24 hours. Decisions for dental services will be made within 14 calendar days.
• Nursing facility services for a short rehabilitative stay (Requires prior authorization.)
• Services for children with medical handicaps (Title V) (Some may require prior authorization.)
• Screening and counseling for obesity (Requires prior authorization.)

Additional covered services include:

• Specialist services (See page 26.)
• Dental care (You may self-refer for routine dental; all other dental care requires prior authorization.)
• Mental health and substance abuse services (You may self-refer to MHAS certified community mental health centers or certified treatment centers. Some services through Paramount Advantage providers may require prior authorization.)

This is only a partial list of covered services. If you need additional information, call the Member Services Department at toll-free 1-800-462-3589, TTY users 1-888-740-5670.

Mental health and substance abuse services.

If you need mental health and/or substance abuse services, please call our Member Services Department at toll-free 1-800-462-3589, TTY users 1-888-740-5670 to assist with understanding how to access services and for assistance in locating a provider.

Paramount Advantage members may receive inpatient and outpatient behavioral services through any Paramount Advantage approved provider, subject to Paramount’s coverage policies. For some mental health services, you will need prior authorization. It is important to contact your PCP first before seeing any specialist.

The Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services were combined under one department. The new department is called the Ohio Department of Mental Health and Addiction Services (MHAS). Members are still allowed to use MHAS-certified community mental health centers and treatment centers that are not on Paramount Advantage’s panel for care.

Or you may self-refer directly to an Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health center or treatment center. Please see your Provider Directory or call our Member Services Department for the names and telephone numbers of the facilities near you.
**Seeing a specialist.**

Although you don’t need a PCP referral before seeing a specialist, it is important to contact your PCP first.

You do not need to contact your PCP before making appointments with obstetricians, gynecologists, certified nurse-midwives, certified nurse practitioners, federally qualified health center/rural health clinic providers, family planning providers, and providers at MHAS certified community mental health centers or certified treatment centers. However, you may still want to discuss this treatment with your PCP.

**Making an appointment with a specialist.**

After your PCP recommends a Paramount Advantage specialist, you may then call that specialist’s office to make an appointment. If you must cancel your appointment, call the specialist’s office as soon as you can.

**Dental benefit.**

The following is not a complete list of covered services. For additional information, call the Member Services Department.

Paramount Advantage members under the age of 21 years are entitled to one initial comprehensive oral examination, followed by a routine oral examination every six months (not before six months after the initial comprehensive oral examination unless medically necessary).

Paramount Advantage adult members (21 years of age or older) are limited to one periodic exam and one cleaning each year. (See page 13).

The following services are covered in the initial and routine oral examinations: X-ray, fillings and simple extraction/restorations. Services that require prior authorization include full and partial dentures, orthodontia, general anesthesia, surgical extraction, and comprehensive restorations such as post and core root canals, and crowns.

**Vision benefit.**

Paramount Advantage members age 21-59 are entitled to one comprehensive vision examination (and one complete frame and pair of lenses) per 24-month period.

Paramount Advantage members under the age of 21 years or age 60 and older are entitled to one comprehensive vision examination (and one complete frame and pair of lenses) per 12-month period (unless medically necessary more often for members under 21). (See page 13).

**New technology assessment.**

Paramount investigates all requests for coverage of new technology using the Hayes Technology Directory as a guideline. If further information is needed, Paramount uses additional sources including Medicare and Medicaid policy, Food and Drug Administration (FDA) releases and current medical literature. This information is evaluated by Paramount’s medical director and other physician advisors.
EXTRA SERVICES AND PROGRAMS

Extra services or programs covered by Paramount Advantage.

Paramount Advantage also offers members the following extra services and/or benefits:

- **Member newsletter** (mailed and online).

- **Nurses** always available to answer questions 24 hours a day. Call the 24 Hour Nurse Line, the ProMedica Call Center at toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750.

- **Health Needs Screening Program** – New member health needs are assessed to determine the need for care management services, especially high-risk cases.

- **Social Services and High-Risk Outreach Programs** – Members with social service needs are referred to community agencies and provided community resource guides. High-risk cases are referred to care management to get the treatment and support they need.

- **Postpartum Home Healthcare Program** – All members are eligible for a minimum of two visits by a nurse from a Paramount Advantage home healthcare provider. (See page 17).

- **Postcard Reminders** for immunizations (shots), Healthcheks, mammograms, and Pap tests (mailed to members as appropriate).

- **Community Resources Guide** for social services and support in your area.

- **NICU Graduate Home Healthcare Program** – Babies who are discharged from the neonatal intensive care unit are eligible for a minimum of two visits by a nurse from a Paramount Advantage home healthcare provider.

- **Prenatal to Cradle Program** – Pregnant members can earn up to $125 in gift cards for completing the recommended number of prenatal/postpartum visits. Contact Paramount Advantage at 1-888-296-0220, TTY 1-888-740-5670 for more information. You may also apply online at www.ParamountAdvantage.org.

- **Transportation Assistance Program** – Paramount Advantage offers additional transportation assistance that includes 30 one-way trips (15 round trips) per member per calendar year to any medical, pharmacy, WIC, or CDJFS redetermination appointment. Transportation must be scheduled at least two (2) business days before your appointment. Transportation must be cancelled within 24 hours of appointment to not count against the number of trips you have used. Members
are permitted one additional passenger to travel with them; all members under 18 require a chaperone. The member is responsible for child car seat or booster as required by law. In addition to share-a-ride cab service, you may also request bus pass or mileage reimbursement where applicable. Please contact Paramount Advantage at 1-866-837-9817, TTY 1-800-750-0750 for assistance.

- If you must travel 30 miles or more from your home to receive covered healthcare services, Paramount Advantage will provide transportation to and from the provider’s office.
- In addition to the transportation assistance that Paramount Advantage provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

- **Paramount Perks** – Special services and programs for Paramount Advantage members, such as gift card drawings and a personalized call center representative service.

- **MyParamount** is your secure member portal. My Paramount will give you access to the Member Handbook, Physician contact information, Securely email Paramount Member Services with questions, FAQs, News & Events.

- **Steps2Care** is free and available on your Android or Apple device. Search for ‘Steps2Care’ in your app store to install. Steps2Care offers guidance on how to react to a medical situation. Should you call your doctor? Treat at home? Or even call 911?

- **Personal Call Center Rep (PCCR)** - When you sign up for a PCCR, you will speak to the same person in Member Services every time you call.

- **Surf our site** from your computer, smartphone, or tablet at www.ParamountAdvantage.org to learn about benefits and programs, transportation assistance, and our Prenatal to Cradle rewards program. You can also find a provider or contact Paramount Advantage directly.

For more information on how to obtain these Paramount Advantage services or programs, call **toll-free 1-800-462-3589, TTY users 1-888-740-5670.**
Care management services.

Paramount Advantage offers care management services that are available to children and adults with special healthcare needs. Care management includes disease management or case management programs.

Disease management is a program where a medical professional (health coach) works with members who have chronic disease to promote wellness.

Case management is a program where RN case managers work with the member, doctors and providers to coordinate care. Case managers educate the member and help the member understand how to care for him/herself, and how to access services that are available through Paramount Advantage participating providers, and also learn about community resources that are available.

In addition, we also have outreach coordinators who may assist with talking to the members regarding the benefits of care management services and assist with the initial case management program process.

Examples of conditions that may qualify for disease management include:

- Chronic kidney disease
- COPD
- CHF
- Depression
- Diabetes mellitus
- Migraines
- Post-cardiac event
- Asthma

Examples of conditions that may qualify for case management would be:

- Difficult pregnancy
- Uncontrolled diabetes
- Severe trauma
- Spinal cord injuries
- Cancer
- Organ transplant
- Major mental health or substance abuse disorder
- Newborn babies with serious complications such as birth defects or prematurity
- Members who frequent the ER
- HIV
- Asthma
- Teen pregnancy

Requests for care management services may come from you, family members, your providers, or from claims information. The case manager, health coach or outreach coordinator will ask questions to learn everything possible about the member’s condition(s).

If you feel that you could benefit from talking to a case manager, please call Member Services and speak to one. You will be able to talk directly to a case manager, or if one is not readily available, a case manager will return your call as soon as he/she is available. Call Member Services at toll-free 1-800-462-3589, TTY users 1-888-740-5670.
Services not covered by Paramount Advantage or Ohio Medicaid.

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

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

This is not a complete list of the services that are not covered by Medicaid or Paramount Advantage. If you have a question about whether a service is covered, please call the Member Services Department.
Let Paramount Advantage know if you are unhappy or do not agree with a decision we made.

Name of Member: ____________________________________________________________________________

Member ID#: ________________________________________________________________________________

Name of Subscriber (if different from member): ________________________________________________

Signature: __________________________________________________________________________________

Has this issue been brought to the attention of an employee of Paramount Advantage before?
If yes, to whom? __________________________________________________________________________
When? ___________________________________________________________________________________

**Nature of complaint.**
State all details relating to the incident in question, including names, dates and places.
Attach additional sheets if necessary.

__________________________________________________________________________________________
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Please mail this form, or other grievance, appeals, and/or complaints to:
Paramount Advantage, Attn: Member Services Department, P.O. Box 928, Toledo, OH 43697-0928
Mail the form or your letter to:

Paramount Advantage
Member Services Appeals Coordinator
P.O. Box 928
Toledo, OH 43697-0928

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

- Deny a request to cover a service for you;
- Reduce, suspend or stop services before you receive all of the services that were approved; or
- Deny payment for a service you received that is not covered by Paramount Advantage.

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

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

If you do not agree with the decision/action listed in the letter, and you contact us within 90 calendar days to ask that we change our decision/action, this is called an appeal. The 90-calendar-day period begins on the day after the mailing date on the letter. Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we have made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

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

- 2 working days for grievances about not being able to get medical care.
- 30 calendar days for all other grievances, except grievances that are about getting a bill for care you have received.
- 60 calendar days for grievances about getting a bill for care you have received.

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

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

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

If you would like to recommend changes to improve Paramount Advantage care and services, please call the Member Services Department at toll-free 1-800-462-3589, TTY users 1-888-740-5670.
State hearings.

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

- A decision is made to deny services.
- A decision is made to reduce, suspend or stop services before all of the approved services are received.
- A provider is billing you because Paramount Advantage has denied payment of the service.
- A decision is made to propose enrollment or continue enrollment in the Paramount Advantage Coordinated Services Program.
- A decision is made to deny your request to change your Paramount Advantage Coordinated Services Program provider.

At the time Paramount Advantage makes the decision or is aware that the provider is billing you for payment, we will mail you a state hearing form. If you want a state hearing, you must request a hearing within 90 calendar days. The 90-calendar-day period begins on the day after the mailing date on the hearing form.

If we have made a decision to reduce, suspend or stop services before all of the approved services are received and you request the hearing within 15 calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first. You may have to pay for services you receive after the proposed date to reduce, suspend or stop services if the hearing officer agrees with our decision. If we propose to enroll you in the Paramount Advantage 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 hearing, you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request via e-mail at bsh@jfs.ohio.gov.

A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from Paramount Advantage, and a hearing officer from the Ohio Department of Job and Family Services. Paramount Advantage will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules.

If you want information on free legal services but don’t know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the MCP or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed, but no later than 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 or health or ability to attain, maintain or regain maximum function.
Membership Terminations, Re-Enrolling and Conversion

Membership terminations (getting out of Paramount Advantage).  

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

Choosing a new plan.  

If you are thinking about ending your membership to change to another health plan, you should learn about your choices. Especially if you want to keep your current doctor(s). Remember, each health plan has its own list of doctors and hospitals that they will allow you to use. Each health plan also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a health plan you are thinking of joining, or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680, TTY 1-800-292-3572. You can also find information about the health plans in your area by visiting the Medicaid Hotline website at www.ohiomh.com.

Ending your MCP membership.  

If you want to end your membership during the first three months of your membership or open enrollment month for your area, you can call the Medicaid Hotline at 1-800-324-8680, TTY 1-800-292-3572. You can also submit a request online to the Medicaid Hotline website at www.ohiomh.com. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

Just cause membership terminations.  

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

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

2. The MCP does not, for moral or religious objections, cover a medical service that you need.

3. Your doctor has said that some of the medical services you need must be received at the same time and all of the
services aren’t available on your MCP’s panel.

4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCP’s panel.

5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers who are experienced in dealing with your special healthcare needs.

6. The PCP that you chose is no longer on your MCP’s panel, and he/she was the only PCP on your MCP’s panel who spoke your language and was located within a reasonable distance from you. Another health plan has a PCP on their panel who speaks your language and is located within a reasonable distance from you and will accept you as a patient.

7. Other – If you think staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to end your membership for just cause by calling the Medicaid Hotline at 1-800-324-8680, TTY 1-800-292-3572. The Ohio Department of Medicaid (ODM) will review your request to end your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the ODM will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the ODM 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.

Optional membership terminations.

Children under nineteen (19) years of age have the option to choose not to be a member of a managed care plan if they are:

- Receiving foster care or adoption assistance under Title IV-E,
- In foster care or other out-of-home placement, or
- Receiving services through the Ohio Department of Health’s Bureau for Children with Medical Handicaps (BCMH).

Additionally, if anyone is a member of a federally recognized Indian tribe, regardless of age, they have the option to not be a member of a managed care plan.

If you believe that you/your child meet any of the above criteria and do not want to be an MCP member, his/her membership will be ended.
Exclusions.

Individuals who are not permitted to join a Medicaid MCP:

- Dually eligible under both the Medicaid and Medicare programs.
- Institutionalized (in a nursing home, long-term care facility, ICF-MR, or some other kind of institution).
- Eligible for Medicaid by spending down their income or resources to a level that meets the Medicaid program’s financial eligibility requirements.
- Receiving Medicaid Waiver services.
- Receiving services through the Ohio Department of Health’s Bureau for Children with Medical Handicaps (BCMH) for a diagnosis of cancer, cystic fibrosis or hemophilia.

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

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 Paramount Advantage 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 health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan’s Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680, TTY 1-800-292-3572.
- 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 health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan’s list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor; a surgery, blood test or X-ray scheduled; and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

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, Paramount Advantage would be told to stop your membership as a Medicaid member, and you would no longer be covered by Paramount Advantage.
Loss of insurance notice (certificate of creditable coverage).

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

Automatic renewal of MCP membership.

If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically become a Paramount Advantage member again.

Can Paramount Advantage end my membership?

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

The reasons that Paramount Advantage can ask to end your membership are:

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

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

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

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

Accidental injury or illness (subrogation).

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

As a member of Paramount Advantage you have the following rights:

- To receive all services that Paramount Advantage must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless Paramount Advantage has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See pages 31-33 of this handbook for information.
- To be able to get all MCP written member information from the MCP:
  - At no cost to you;
  - In the prevalent non-English languages of members in the MCP’s service area;
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from Paramount Advantage and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the healthcare provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 40 which explains about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on Paramount Advantage’s panel at least monthly. Paramount Advantage 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 the MCP, the MCP’s providers or Ohio Department of Medicaid will not hold this against you.
- To know that the MCP must follow all federal and state laws and other laws about privacy that apply.
• To choose the provider that gives you care whenever possible and appropriate.
• If you are a female, to be able to go to a woman's health provider on Paramount Advantage's panel for covered women's health services.
• To be able to get a second opinion from a qualified provider on Paramount Advantage's panel. If a qualified provider is not able to see you, Paramount Advantage must set up a visit with a provider not on our panel.
• To get information about Paramount Advantage from us.
• To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services.

Advance directives.

Paramount Advantage will not discriminate against any individual based on whether or not the individual has executed an advance directive and will not require advance directives as a condition of coverage. Paramount Advantage has policies and procedures to ensure that if a member has advance directives that person's wishes will be honored.

Using advance directives to state your wishes about your medical care.

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

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

You have a choice.

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

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

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

This information also explains how you can state your wishes about the care you would want if you could not choose for yourself.
This information does not contain legal advice, but will help you understand your rights under the law.

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

What are my rights to choose my medical care?
You have the right to choose your own medical care. If you don’t want a certain type of care, you have the right to tell your doctor you don’t want it.

What if I’m too sick to decide? What if I can’t make my wishes known?
Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want.

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

What kinds of forms are there?
Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a living will, a declaration for mental health treatment, a durable power of attorney for medical care, or a do not resuscitate (DNR) order.

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

Do I have to fill out an advance directive before I get medical care?
No. No one can make you fill out an advance directive. You decide if you want to fill one out.

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

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

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

Living will.

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

How does a living will work?
A living will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

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

The people giving you medical care must do what you say in your living will. A living will gives them the right to follow your wishes.
Only you can change or cancel your living will. You can do so at any time.

Do not resuscitate order.

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

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

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

Durable power of attorney.

A durable power of attorney for medical care is different from other types of powers of attorney. This information talks only about a durable power of attorney for medical care, not about other types of powers of attorney.

A durable power of attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can’t act for yourself. This could be for a short or a long while.

Who should I choose?

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

When does my durable power of attorney for medical care take effect?

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

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

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

Declaration for mental health treatment.

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

The declaration for mental health treatment supersedes a durable power of attorney for mental health care, but does not supersede a living will.
Advance directives.

**What is the difference between a durable power of attorney for medical care and a living will?**
Your living will explains, in writing, the type of medical care you would want if you couldn’t make your wishes known.

Your durable power of attorney lets you choose someone to carry out your wishes for medical care when you can’t act for yourself.

**If I have a durable power of attorney for medical care, do I need a living will, too?**
You may want both. Each addresses different parts of your medical care.

A living will makes your wishes known directly to your doctors, but states only your wishes about the use of life-support methods.

A durable power of attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can’t act for yourself. A durable power of attorney for medical care does not supersede a living will.

**Can I change my advance directive?**
Yes, you can change your advance directive whenever you want.

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

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

**Other matters to think about.**

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

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

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

Where do I get advance directive forms? 
Many of the people and places that give you 
medical care have advance directive forms. Ask 
the person who gave you this information for 
an advance directive form – either a living will, 
a durable power of attorney for medical care, a 
DNR order, or a declaration for mental health 
treatment. A lawyer could also help you.

What do I do with my forms after filling 
them out? 
You should give copies to your doctor and 
healthcare facility to put into your medical 
record. Give one to a trusted family member 
or friend. If you have chosen someone in a 
durable power of attorney for medical care, 
give that person a copy.

Put a copy with your personal papers. You may 
want to give one to your lawyer or clergy 
person.

Be sure to tell your family or friends about what 
you have done. Don’t just put these forms 
away and forget about them.

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

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

1. You can state your wishes for organ 
and/or tissue donation when you obtain 
or renew your driver’s license or state 
ID card, or
2. You can complete the donor registry 
enrollment form that is attached to the 
Ohio living will form, and return it to the 
Ohio Bureau of Motor Vehicles.

This information is endorsed by the following 
organizations:

• Association of Ohio Philanthropic Homes 
and Housing for the Aging
• Office of the Attorney General, State 
of Ohio
• Ohio Academy of Nursing Homes
• Ohio Council for Home Care
• Ohio Department of Aging
• Ohio Department of Health
• Ohio Department of Job and Family 
Services
• Ohio Department of Mental Health
• Ohio Health Care Association
• Ohio Hospice Organization
• Ohio Hospital Association
• Ohio State Bar Association
• Ohio State Medical Association
Members have the responsibility to:

- Provide, to the extent possible, information that Paramount Advantage and the participating providers need to care for you. Help your primary care provider (PCP) fill out current medical records by providing current prescriptions and your previous medical records.
- Engage in a healthy lifestyle, become involved in your health care and follow the plans and instructions for the care that you have agreed upon with your PCP or specialists.
- Continue seeing your previous PCP until the transfer takes effect.
- Obtain medical services from your Paramount Advantage PCP.
- Treat your PCP and her/his staff in a polite and courteous manner.
- Treat your PCP with respect and dignity.
- Inform your PCP of any symptoms and problems, and to ask questions.
- Carry your ID card at all times and report any lost or stolen cards to Paramount Advantage immediately. Also, contact Paramount Advantage if any information on the card is incorrect or if you have changes in name, address or eligibility.
- Schedule and keep appointments and be on time. Always call if you need to cancel or if you will be late.
- Although a PCP referral is not required, contact your PCP, or the doctor or facility taking your calls, before seeing a consultant/specialist. You do not need to contact your PCP before making appointments with obstetricians, gynecologists, certified nurse practitioners, certified nurse-midwives, federally qualified health center/rural health clinic providers, family planning providers, and MHAS certified community mental health centers or certified treatment centers.
- Obtain information and consider the information about any treatment or procedure before it is done. Discuss any problems in following the recommended treatment with your PCP.
- Respect the privacy of the other patients in the office.
- Learn and follow the policies and procedures as outlined in this handbook.
- Continue following Paramount Advantage policies and procedures until disenrollment takes effect.
- Indicate to your doctor who you wish to designate to receive information regarding your health.
- Inform Paramount Advantage and your caseworker of any dependent to be added or removed from coverage.
- Contact your PCP as soon as possible if you have received emergency treatment, and notify Paramount Advantage within 48 hours.
- Call the Member Services Department if you have a problem and need assistance.
Patient safety.

Paramount Advantage is working with other hospitals, doctors and health plans to educate our members about patient safety. It is always important that you play an active role in decisions about your health and your health care. Take responsibility – you can make a difference!

Here are some of the ways you can improve the safety of your medical care:

- Provide your doctors with a complete health history.
- Be an active member of your healthcare team. Take part in every decision about your health care. Speak up – ask questions.
- Make sure all of your doctors know about everything you are taking, including over-the-counter medications and herbal/dietary supplements.
- Make sure your doctors know about any allergies and reactions you have had to medications.
- Ask for your test results. Don’t assume that no news is good news.
- Advise your doctor of any changes in your health.
- Follow your doctor’s advice and the instructions for care you and your doctor have agreed on.
- Make sure that you can read the prescriptions you get from your doctor.
- Ask your doctor and pharmacist questions about your medications:
  - What is this medication for?
  - What are the brand and generic names of the medication?
  - What does the medication look like?
  - How should it be taken and for how long?
  - What should you do if you miss a dose?
  - How should you store the medication?
  - Does the medication have side effects?
  - What are they? What should you do if they occur?
- When you pick up the medication, ask the pharmacist if this is the medication that was prescribed.
- Make sure that you understand the instructions on the label.
- Ask the pharmacist about the best device to measure liquid medications.
- Read the information that is provided by the pharmacy.
If you ever find yourself in the hospital, you’ll likely have many healthcare workers taking care of you. While they make every effort to provide appropriate care, sometimes errors can happen.

By taking an active role in your care and asking questions, you can help make sure the care you receive is right for you.

If you are told you need hospital care, be sure to:

• **Do your homework.** Make sure that the hospital you’re being treated in has experience in treating your condition. If you need help getting this information, ask your doctor or call the Paramount Advantage Member Services Department.

• **See that healthcare workers wash their hands before caring for you.** This is one way to prevent the spread of germs at home and infections in a hospital. Studies have shown that when patients checked whether healthcare staff had washed their hands, the workers washed their hands more often and used more soap.

• **Ask about services or tests.** Make sure to ask what test or X-ray is being done to make sure you are getting the right test. In the example of a knee surgery, be sure that the correct knee is prepped for surgery. A tip from the American Academy of Orthopaedic Surgeons urges doctors to sign their initials on the site to be operated on before surgery.

• **Ask about what to do when you get home.** Before leaving the hospital, be sure the doctor talks to you about any medicines you need to take. Make sure you know how often, what dose to take and any side effects to expect from the medicine. Also, ask when you can return to your regular activities. See if the doctor has advice or things you can do to help your recovery.

If you have any questions or if things just don’t seem right after you come home, be sure to call your doctor right away.
Meanings of Some Words in This Handbook

Benefits – A list of covered healthcare services. See page(s) 23-29.

Care Management – A program where a health coach or a case manager works directly with members with difficult health problems and their PCP to assist in coordinating care to improve health outcomes, increase members’ quality of life and assist the member with navigating the complex healthcare system. See page(s) 17, 29.

Case Manager – A registered nurse who works closely with the members, doctors and providers to educate members who have serious healthcare issues. See page(s) 17, 29.

Complaint (same as Grievance) – See page(s) 8, 31, 39.

Durable Medical Equipment – Equipment for medical uses, such as wheelchairs, oxygen tanks, diabetic supplies or aerosol machines. See page(s) 17, 22, 24.

EPSDT (same as HealthChek) – Early and Periodic, Screening, Diagnostic and Treatment. See page 14.

Emergency – An unexpected, serious condition that requires immediate medical assistance when you think your health or the health of your unborn infant is in jeopardy. See page(s) 11-12.

Generic Drug – A prescription drug approved by the U.S. Food and Drug Administration which has the same active ingredients as a trade-name drug. See page 21.

Grievance – A complaint which members or their authorized representative present to a managed care plan (MCP) because they are unhappy with something about the MCP or one of their providers. See page(s) 8, 31, 39.

HealthChek – A well-child check-up for children and youth under the age of 21 years that can uncover dental and medical problems before the problems become serious. See page 14.

Health Coach – A medical professional who works closely with members who have chronic disease to promote wellness. See page 29.

Health Maintenance Organization (HMO) – See Managed Care Plan. See page 7.

Home Health Agency – A company that provides healthcare services in your home. See page 24.

Hospital – An institution approved by the State of Ohio that offers a full range of diagnoses and surgeries for treating injured and sick people 24 hours a day.

Identification Card – A personalized card for each Paramount Advantage member that must be presented before you can receive services such as check-ups, entering the hospital or picking up prescriptions. See page(s) 9, 13, 14, 37, 38, 45.

Inpatient – A service or treatment at a hospital that requires an overnight stay.
Managed Care Plan (MCP) (formerly known as HMO) – A company that makes arrangements for specific doctors, hospitals and other healthcare providers to work with MCP members to keep them healthy. See page 7.

Medically Necessary Services – Services which are necessary for the diagnosis or treatment of disease, illness or injury and without which the patient 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. See page(s) 15, 21-23, 26, 30, 36.

Member – A person – sometimes called an enrollee – eligible for benefits through Paramount Advantage. Member Services Department – A department at Paramount Health Care that can be reached by telephone or in person to answer questions and solve complaints promptly. Open Monday – Friday, 7:00 a.m. – 7:00 p.m. (except on holidays). Paramount Advantage is closed on New Year’s Day, Memorial Day, Independence Day (July 4), Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day. If the Paramount-recognized holiday occurs on a Saturday, the Member Services Department will be closed on the preceding Friday. If the Paramount-recognized holiday occurs on a Sunday, the Member Services Department will be closed on the following Monday. See page(s) 7-9.

MHAS – Ohio Department of Mental Health and Addiction Services. See page(s) 13, 22, 25.

OB or Gyn – Obstetrics or gynecology. See page(s) 16, 26.

ODM – Ohio Department of Medicaid. See page(s) 33, 35, 36, 38.

Outpatient – A service or treatment at a hospital that does not require an overnight stay.

Participating Provider – Any doctor, hospital, laboratory, or other healthcare provider holding a contract with Paramount Advantage to provide care for members. See page(s) 13, 45.

Prescription Medicine – A drug that can be obtained at the pharmacy if the doctor has written an advance note, sometimes called an order. See page 21.

Primary Care Provider (PCP) – Your personal doctor who coordinates your health care and participates with Paramount Advantage. A PCP is usually trained in family practice medicine, internal medicine, pediatrics, or is an advance practice nurse. See page(s) 7, 13.

Prior Authorization – A process of receiving prior approval from Paramount Advantage before receiving certain services. The review process occurs between Paramount Advantage providers and the Utilization Review Department and is performed by phone, fax or web-based tool. Paramount Advantage will make the decision within two working days. An approval notice will be sent to you within three workings days of the decision. If the decision is a denial, the notice will be mailed to you at the same time the decision is made. Decisions are made quicker if your condition is such that you cannot wait two working days for a decision to receive the service. Exceptions to the time frame for making a decision are:

- Dental request – Within 14 calendar days of receiving the dental request, you will be notified of the approval or denial decision.
- Requests for drugs administered in a provider setting or obtained at a pharmacy will be decided in 24 hours.
24-Hour Nurse Line, the ProMedica Call Center – A special service available 24 hours a day with general health information plus a staff of nurses to assist you. Please call toll-free 1-800-234-8773, or the Ohio Relay Service TTY toll-free 1-800-750-0750. See page(s) 2, 12, 21, 24, 26.

Provider Panel – is a listing of all Paramount Advantage medical providers you can use to receive service. See page(s) 13, 45.

Referral – The process by which a primary care provider orders treatment for a patient from other Paramount Advantage providers. You do not need a referral authorization from Paramount Advantage to see any Paramount Advantage specialist. See page(s) 26, 45.

Specialist – A doctor who provides covered services to members within his/her area of practice and who has an agreement with Paramount Advantage. See page 26.

Terminations – Steps to follow to leave Paramount Advantage. See page 35.

Transportation – Transportation Each member is eligible for 15 Round Trips (or 30 one-way trips) to medically necessary appointments each calendar year. See page(s) 24, 27-28.

Urgent Care Center – A category of a walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional emergency room. Urgent care centers primarily treat injuries or illnesses requiring immediate care, but not serious enough to require an ER visit. See page 12.

Utilization Management (UM) – The evaluation and determination of the appropriateness of patient use of medical care resources and provision of any needed assistance to clinician and/or enrollee, to ensure appropriate use of resources (may include prior authorization, concurrent review, discharge planning, and care management). Paramount Advantage does not provide financial incentives for UM decision makers to encourage decisions that result in underutilization. Denial of services can only be made by medical, associate, and clinical directors; pharmacists; or a Paramount Advantage designated utilization management delegated entity or subspecialist.

Utilization Review (UR) – A review process by which decisions for care are based on whether a service is a Medicaid-covered service and medically necessary. Paramount Advantage follows NCQA standards for utilization review. All determinations for non-urgent care are made within two working days. Determinations for concurrent care (care in process) are made within one working day. Decisions for drug requests are made within 24 hours. Decisions for dental services will be made within 14 calendar days.

Denials are documented in the form of a letter to members, offering alternatives for care including options that would be covered, if applicable. The letter also includes instructions on grievance procedures and appeal and state hearing rights. See page 24.
IMPORTANT NUMBERS & INFORMATION

Member Services: 1-800-462-3589, TTY 1-888-740-5670
General questions, find a provider, get a Provider Directory, get a new ID Card, change your PCP. (See page 7)

24 Hour Nurse Line - the ProMedica Call Center: 1-800-234-8773, TTY 1-800-750-0750
Medical Questions: get information on handling sickness or injury, find out when it’s appropriate to see your Dr, Urgent Care, and/or Emergency Room. (See pages 8, 12)

Mobile Website: www.ParamountAdvantage.org
Get easy access at your fingertips to: Benefits & Programs, Transportation, Prenatal to Cradle, Community Resources, Find a Provider, and much more. (See page 28)

Transportation Scheduling: 1-866-837-9817, TTY 1-800-750-0750
15 Round Trips (or 30 one-way trips) to medical appointments each calendar year, must be scheduled 2 or more business days ahead. (See page 27)

Prenatal to Cradle Pregnancy Reward Program: 1-888-296-0220, TTY 1-888-740-5670
You may enroll online via the mobile website or have a registration mailed to you. Enroll as soon as you find you are pregnant, earn up to $125 in gift cards. (See page 27)

Online Member Portal: www.MyParamount.org
Register securely and you can:
• Easily Search Providers
• Change your Primary Care Physician
• Chat with Member Services
• Access your ID Card or Order a New One
• Link your Family into One Account
• View Wellness Reminders & Health News (See page 28)