



ambetter.[®]

of Illinois

*Insured by Celtic
Insurance Company*

2023

Quick Reference Guide

The Resources You Need. Right Here.

For more information, visit [Ambetterofillinois.com](https://www.Ambetterofillinois.com)

If this information is not in your primary language, please call 1-855-745-5507 (TTY 1-844-517-3431)

Welcome to Ambetter of Illinois!

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

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

- How your plan works
- Payment information
- Where to go for care
- Information on your Member ID
- Optional adult dental and vision benefits
- Telehealth
- And much more!

YOUR HEALTH IS OUR PRIORITY.

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

Member Services:

1-855-745-5507 (TTY 1-844-517-3431)

AmbetterofIllinois.com



How To Contact Us

How To Contact Us

Ambetter of Illinois

PO Box 733

Elk Grove Village, IL 60009-0733

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

Member Services	1-855-745-5507
Fax	1-855-519-5699
TTY	1-844-517-3431
Make a Payment	1-855-745-5507
Behavioral Health Services	1-855-745-5507
24/7 Nurse Advice Line	1-844-494-9165
Complaints and Grievances	1-855-745-5507
Emergency	911
Website	Ambetterofillinois.com

When you call, have these items ready:

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

Interpreter Services

Please call Member Services at 1-855-745-5507 (TTY 1-844-517-3431) for free interpreter services as needed. Interpreter services include languages other than English. This service allows you and your provider to talk about your medical or behavioral health concerns in a way that is most comfortable for you. Members who are blind or visually impaired and need help with interpretation can call Member Services for an oral interpretation.

How Your Plan Works

Learn about how to get the most out of your plan. Set up your online member account to get started.



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

So You Have Health Insurance — Now What?

Having health insurance is exciting. To get the most out of your plan, complete this simple checklist. If you need assistance, call Member Services at 1-855-745-5507 (TTY 1-844-517-3431). We're available Monday through Friday, 8 a.m. to 8 p.m. CST.

- 1** Set up your secure online member account. Do this by visiting the “Member Login” page on Ambetterofillinois.com. Your member account stores all of your plan’s benefits and coverage information in one place. It gives you access to your *Schedule of Benefits*, claims information, this QRG and more.
- 2** Our *myhealthpays*® program helps you focus on your total health. When you complete healthy activities, such as eating right, moving more, saving smart and living well, you can earn reward points! All you have to do is log in to your online member account to get started.
- 3** Enroll in automatic bill pay. Call us or log in to your online member account to sign up. Automatic bill pay automatically withdraws your monthly premium payment from your bank account. It’s simple, helpful, convenient and secure.
- 4** Pick your primary care provider (PCP). Just log in to your member account and view a list of Ambetter providers in your area by using the *Provider Directory* available on our website. Remember, your PCP, also known as a personal doctor, is the main doctor you will see for most of your medical care. This includes your checkups, sick visits and other basic health needs.
- 5** Schedule your annual wellness exam with your PCP. After your first checkup, you’ll earn 500 points in *myhealthpays*® rewards! And anytime you need care, call your PCP and make an appointment!

Funds expire immediately upon termination of insurance coverage. My Health Pays® rewards cannot be used for pharmacy copays. Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all members. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 1-855-745-5507 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.



Answers To Your Payment Questions



If you have questions about paying your premium, give member services a call at 1-855-745-5507 (TTY 1-844-517-3431).



Sign up for Paperless Billing to receive your monthly invoices online.

How Can I Pay My Monthly Premium?

1. Pay online (Our recommendation!)

- a. **Quick Payment:** <https://centene.softtheon.com/Equity/#/search> or visit Ambetterofillinois.com and select “pay now”.
- b. **Secure Member Account:** Create your online member account on Ambetterofillinois.com and enroll in automatic bill payment. You can set up automatic bill pay using your credit card, prepaid debit card, bank debit card or bank account. You can also make a one-time payment via your online member account.
- c. If you have earned My Health Pays[®] rewards, you can use your rewards to help pay your monthly premiums. Log in to your secure member account at Member.AmbetterHealth.com to learn more about the My Health Pays[®] program and view your card balance.

2. Pay by phone

- a. Pay by Automated Phone. Call us at 1-844-PAY-BETTER (729-2388) and use our Interactive Voice Response (IVR) system. It’s quick and available 24/7!

Or

- b. Call billing services at 1-855-745-5507 (TTY 1-844-517-3431) between 8 a.m. and 8 p.m. CST. You will have the option to pay using the Interactive Voice Response (IVR) system or by speaking to a billing services representative.

3. Pay by mail

- a. Send a check or money order to the address listed on your billing invoice payment coupon. **Be sure to mail your payment at least seven to 10 days prior to your premium payment due date. Remember to write your member ID number on the check or money order and detach the payment coupon from the billing invoice and mail with your payment.**
- b. Mailing to the correct address will ensure your payments are processed in a timely manner.

Ambetter of Illinois

Attn: Billing Services
PO Box 74008544
Chicago, IL 60674-8544





We Care About Your Health

How Can I Pay My Monthly Premium?

(Continued)

- c. To find a MoneyGram location near you, or to make an Ambetter payment with MoneyGram go to <https://www.moneygram.com/mgo/us/en/paybills> or call 1-800-926-9400.

What Happens If I Pay Late?

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

If you don't pay your premium before its due date, you may enter a grace period. This is the extra time we give you to pay. During a grace period, we may hold — or pend — payment of your claims. During your grace period, you will still have coverage. However, if you don't pay before a grace period ends, you run the risk of losing your coverage. Refer to your Evidence of Coverage for grace period details.

Member Services

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

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

If you enrolled through the Health Insurance Marketplace you must contact them to: update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter. You can do this by visiting [Healthcare.gov](https://www.healthcare.gov) or calling 1-800-318-2596 (TTY: 1-855-889-4325). When you are connected, be ready to provide your state and then ask for a representative to help you.

If you are enrolled in an off-exchange plan, please contact Member Services to update your enrollment information, such as your date of birth, address or income or life changes; or to end your coverage with Ambetter.



Have total or partial hearing loss? Call 1-855-745-5507 (TTY 1-844-517-3431) or visit [AmbetterofIllinois.com](https://www.AmbetterofIllinois.com)

Membership & Coverage Information



Your Ambetter Member Welcome Packet

When you enroll with Ambetter, you will receive a Member Welcome Packet. Your Welcome Packet includes basic information about the health plan you selected. You will receive your Welcome Packet before your Ambetter health coverage begins.


Your Ambetter Member ID

Your member ID is proof that you have health insurance with us. And it's very important. Here are some things to keep in mind:

- Keep this card with you at all times
- You will need to present this card anytime you receive healthcare services
- You will receive your Member ID(s) before your Ambetter health coverage begins. If you don't get your Member ID before your coverage begins, call Member Services at 1-855-745-5507 (TTY 1-844-517-3431). We will send you another card.
- You will not receive your Welcome Packet and Member ID(s) until your binder payment and first month's premium are paid in full.

To download your Digital ID, request a replacement ID or request a temporary ID, please log into your secure member account.


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



Subscriber: [Jane Doe] **Policy #:** [XXXXXXXXXX]

Member: [John Doe] **Member ID #:** [XXXXXXXXXXXX]

Effective Date: [00/00/00]



[Ambetter ID #] / copays

PCP: [\$10 coin. after ded.]

Specialist: [\$25 coin. after ded.]

Rx (Generic/Brand): [\$5/\$25 after Rx ded.]

Urgent Care: [20% coin. after ded.]

ER: [\$250 copay after ded.]

Max Out-of-Pocket: [\$25,000]

Plan: [Plan name]

[Line 2 if needed]

[Network Name] Network Coverage Only

RXBIN: [004336]


RXPCN: [ADV]

RXGROUP: [RX5485]

REFERRAL FROM PCP REQUIRED FOR SPECIALIST

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Ambetterofillinois.com

<p>Member/Provider Services: 1-855-745-5507 TTY/TDD: 1-844-517-3431 24/7 Nurse Line: 1-855-745-5507</p> <p>Numbers below for providers: Pharmacy Help Desk: 1-844-256-4050 EDI Payor ID: 68069</p>	<p>Medical Claims: Ambetter of Illinois Attn: CLAIMS PO Box 5910 Farmington, MO 63640-5910</p> <p>can receive 20% off Walgreens brand health and wellness items*</p> 
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Additional information can be found in your Evidence of Coverage. If you have an Emergency, call 911 or go to the nearest Emergency Room (ER). Emergency services given by a provider not in the plan's network will be covered without prior authorization. Receiving non-emergent care through the ER or with a non-participating provider may result in a change to member responsibility. For updated coverage information, visit Ambetterofillinois.com.

* Exclusions and restrictions apply. See Walgreens.com/SmartSavings for details.

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Refer to your *Evidence of Coverage* for information on Dependent Member Coverage.

Finding the Right Care



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

To search our online Provider Directory, visit guide.ambetterhealth.com and use our **Ambetter Guide- the new Ambetter provider search tool**. This guide will have the most up-to-date information about our provider network, including information such as name, address, telephone numbers, hours of operation, professional qualifications, specialty, and board certification. It can help you find a primary care provider (PCP), pharmacy, lab, hospital or specialist. You can narrow your search by:

- Provider specialty
- ZIP code
- Gender
- Languages spoken
- Whether or not they are currently accepting new patients

A Provider Directory is a listing of providers near you. If you would like a printed copy of this listing, please call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

In-Network or Network Provider means a physician or provider who is identified in the most current list for the network shown on your Member ID.

Out-of-Network or Non-Network Provider means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage* (EOC).

Throughout the year, the providers available in-network may change. It is important that you review the provider directory for the latest information on whether or not the provider you are planning to see is in-network. We encourage you to ask the providers if they participate with Ambetter **before they treat you**, so you know whether you may receive an additional bill for their services.



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

Refer to your *Evidence of Coverage* for more information on your Provider Directory.



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

Get The Right Care At The Right Place

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

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

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

And remember — always make sure your providers are in-network.

Using in-network providers can save you money on your healthcare costs.

Every time you receive medical care, you will need your member ID.

Learn more about your options <https://AmbetterofIllinois.com/resources/handbooks-forms/where-to-go-for-care.html>



Your Primary Provider (PCP)

Your primary care provider is your main doctor — the one you see for regular checkups. If your condition isn't life-threatening, calling your PCP should be your first choice. Use our online Ambetter Guide to find an in-network provider in your area.

Visit or call your PCP if you need:

- Your annual wellness checkup & vaccinations
- Advice about your overall health
- Help with medical problems such as cold, the flu and fevers
- Treatments for an ongoing health issue like asthma or diabetes

Selecting A Different PCP

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

- 1. Click on Coverage or Edit Account**
- 2. Under the My Primary Care Provider section, pull up the Ambetter Guide to search for an in-network PCP.**
- 3. Pick a PCP from the list. Make sure you select a PCP who is currently accepting new patients.***

To learn more about a specific PCP, call 1-855-745-5507 (TTY 1-844-517-3431). You can also visit AmbetterofIllinois.com to see our provider list on our **Find a Doctor** web page.

**If you choose a nurse practitioner or physician assistant as your PCP, your benefit coverage and co-payment amounts are the same as they would be for services from other participating providers. Review your Schedule of Benefits for more information.*

When Do You Need A Referral?

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

Your benefits may be reduced or not covered if referral requirements are not met. In addition a prior authorization may be required for certain services.

Refer to your *Evidence of Coverage* Policy for more information.



Ambetter Telehealth

Ambetter Telehealth is our 24-hour access to in-network virtual healthcare providers when you have a non-emergency health issue. It's available to use when you're at home, in the office or on vacation.

Before you start using Ambetter Telehealth, you will need to set up your account at AmbetterTelehealthIL.com.

Ambetter Telehealth providers are available by phone or video when you need medical care, a diagnosis or a prescription. As part of our Health Management Program, Ambetter offers \$0 copay for in-network telehealth through Ambetter Telehealth providers. You can choose to receive immediate care or schedule an appointment for a time that fits in your schedule.

Contact Ambetter Telehealth for illnesses such as:

- Colds, flu and fevers
- Rash, skin conditions
- Sinus problems, allergies
- Upper respiratory infections, bronchitis
- Pink Eye

Ambetter does not provide medical care. Medical care is provided by individual providers through Teladoc Health.

\$0 Telehealth copay does not apply to plans with HSA until the deductible is met. \$0 copays are for in-network medical care. \$0 copays are for in-network services through Ambetter Telehealth. Telehealth services through other providers is the same cost share as if seeing the provider in-person.

24/7 Nurse Advice Line

Our free 24/7 nurse advice line makes it easy to get answers to your health questions. You don't even have to leave home! Staffed by licensed nurses, our 24/7 nurse advice line runs all day, every day. 1-855-745-5507 (TTY 1-844-517-3431) if you have questions about:

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



To find another provider or specialist in our network, check out our provider list on the **Find a Doctor** page at guide.ambetterhealth.com



WHAT TO DO IF YOU RECEIVE A BILL FROM A PROVIDER OR PHYSICIAN:

When seeing an in network provider, including but not limited to physicians, hospitals, pharmacies, facilities and health care professionals, you are responsible for any applicable cost sharing amounts (e.g. co-pay, deductible or co-insurance). Your member responsibility can be viewed on the explanation of benefits. This can be found by logging into your secure account at AmbetterofIllinois.com.

As a member of Ambetter, non-network providers should not bill you for covered services for any amount greater than your applicable in-network cost sharing responsibilities when:

- You receive a covered emergency service or air ambulance service from a non-network provider. This includes services you may get after you are in stable condition, unless the non-network provider obtains your written consent to bill you for their service.
- You receive non-emergency ancillary services (emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services)) from a non-network provider at a network hospital or network ambulatory surgical facility.
- You receive other non-emergency services from a non-network provider at a network hospital or network ambulatory surgical facility, unless the non-network provider obtains your written consent to bill you for their service.

If you receive a bill for services in the above situations, please contact Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

Refer to your *Evidence of Coverage* for information on Balance Billing and Eligible Service Expenses.

Member Complaints, Grievances, & Appeals Process



We have steps for handling any problems you may have. To keep you satisfied, we provide processes for filing appeals or complaints. You have the right to file a complaint, file an appeal, and the right to an external review.

If You're Not Happy With Your Care

We hope you will always be happy with our providers and us. But if you aren't, or you aren't able to find answers to your questions, we have steps for you to follow:

- Inquiry Process
- Complaint Process
- Grievance Process
- Appeal Process
- External review by an independent review organization (IRO)
- Complaint to the state Department of Insurance (DOI)

Your satisfaction is very important to us. We want to know your issues and concerns so we can improve our services. Please contact our Member Services team at 1-855-745-5507 (TTY 1-844-517-3431) if you have questions or concerns. We will attempt to answer your questions during initial contact, as most concerns can be resolved with one phone call.

The following processes are available to address your concerns.

How to Make an Inquiry

An Inquiry is a request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made. Examples of an Inquiry could be:

- "Can I make a payment?"
- "Can you help me change my Primary Care Provider?"
- "Why did I receive this bill?"
- "Why did my premium change?"
- "Can I get a copy of my ID?"
- "Can you help me find a Provider?"

How To File A Complaint

A complaint can be an appeal or a grievance. Some complaints can be resolved through first call resolution if they can be fully addressed and closed.

Examples of a Complaint could be:

- "I can't get an appointment with the doctor for 4 months"
- "I can't find a provider in my area, as the local doctors are all stating they are not participating with my plan and the ones participating with my plan are too far away"
- "I've called Member Services multiple times and my issue is still not resolved"



How To File A Complaint (Continued)

- “I can’t get enrolled on your website”
- “I can’t find what I am needing on your website”
- “The doctor and/or the staff were rude to me”

To file a complaint, call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

How to File a Grievance

Grievance means any dissatisfaction with an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed verbally or in writing to the insurer by, or on behalf of, a claimant including any of the following:

1. Providing of services.
2. Claims practices.

Examples of a Grievance would be:

- “My generic prescription didn’t have the generic co-pay applied”
- “I had a preventive procedure and they are making me pay out of pocket, when it should have been covered at 100%”
- “I’m in need of home healthcare and I haven’t gotten a call back from my Case Coordinator”
- “I did not consent to blood products during surgery but found out they gave me some anyway”
- “My doctor prescribed a medication that I’m allergic to and I’ve had a terrible reaction”
- “I was told that I was active with the plan, and the plan kept taking premiums out automatically, but now they are going back and saying I had no coverage for 10 months, and now I have over \$100,000.00 in hospital bills”

To file a grievance, call Member Services at 1-855-745-5507 (TTY 1-844-517-3431). You may file a grievance, verbally, or in writing, either by mail or by facsimile (fax). If you require assistance in filing a grievance or if you are unable to submit the grievance in writing, you can call Member Services at 1-855-745-5507 (TTY 1-844-517-3431) to ask for help through the process. We will send a Grievance Acknowledgment letter after receipt of your Grievance.

Send your written Grievance form to:

Ambetter of Illinois
Attn: Appeals & Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

Expedited Grievance: If your grievance concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if a standard resolution process will risk serious jeopardy to your life or health.

Standard Grievance: A grievance that does not meet the Expedited definition.

For a full list of definitions, please refer to your *Evidence of Coverage*.



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

For a full list of definitions, please refer to your *Evidence of Coverage*.

How to File a Grievance (Continued)

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

You may also file a Grievance with the Department of Insurance (DOI). There are several ways to file a Grievance with the DOI. Refer to your *Evidence of Coverage* for more information.

How To File An Appeal

An Appeal is a request to reconsider a decision about the member's benefits where either a service or claim have been denied. A denial includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. Failure to approve or deny a prior authorization request timely may be considered as a denial and also subject to the appeal process.

Examples of an Appeal would be:

1. Access to healthcare benefits, including an Adverse Determination made pursuant to utilization management;
2. Admission to or continued stay in a healthcare Facility;
3. Claims payment, handling or reimbursement for healthcare services;
4. Matters pertaining to the contractual relationship between a Member and us;
5. Cancellation of your benefit coverage by us;
6. Other matters as specifically required by state law or regulation

To file a written appeal, you can mail or Fax your request to us. Our contact information is below:

Ambetter of Illinois
Attn: Appeals & Grievances Department
PO Box 10341
Van Nuys, CA 91410
Fax: 1-833-886-7956

To file a verbal appeal, you can call us at 1-855-745-5507 (TTY 1-844-517-3431).

Resolution timeframes may vary based on the type of appeal filed. Please see *Evidence of Coverage* for details.

Expedited Appeal: If your appeal concerns an emergency or a situation in which you may be forced to leave the hospital prematurely, or if you believe a standard resolution process will risk serious jeopardy to your life or health.

Standard Appeal: An appeal that does not meet the Expedited definition.



Continued Coverage During An Appeal

If we are going to reduce or stop a service we had previously approved and the time limit we have approved has not ended, you have the right to request to keep getting the service until:

- The end of the approved treatment period

OR

- The determination of the appeal

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

You can request continued services by calling Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

NOTE: You can't request an extension of services after the original authorization has ended. For more details, call Member Services at 1-855-745-5507 (TTY 1-844-517-3431).

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



What Is Utilization Management?

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

We will approve all covered benefits that are medically necessary. Our UM Department checks to see if the service needed is a covered benefit. If it is a covered benefit, the UM nurses will review it to see if the service requested meets medical necessity criteria. They do this by reviewing the medical notes and talking with your doctor. Ambetter does not reward practitioners, providers or employees who perform utilization reviews, including those of the delegated entities. UM's decision making is based only on appropriateness of care, services, and existence of coverage. Ambetter of Illinois does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

What Is Utilization Review?

Ambetter reviews services to ensure the care you receive is the best way to help improve your health condition. Utilization review includes:

Preservice or prior authorization review

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

To see if a service requires prior authorization, check with your PCP, the ordering provider, or Ambetter Member Services. When we receive your prior authorization request, our nurses and doctors will review it. If prior authorization is not received on a medical service when required, you may be responsible for all charges.

Concurrent review

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

Retrospective review

Retrospective review takes place after a service has already been provided. Ambetter may perform a retrospective review to make sure the information provided at the time of authorization was correct and complete. We may also evaluate services you received due to special circumstances (for example, if we didn't receive an authorization request or notification because of an emergency).

Notification of Approved Services

All claims information (including prior authorizations) can be found by logging into the member secure portal and selecting the activity and usage link.



What Is Utilization Review? (Continued)

Adverse determinations and appeals

An adverse determination occurs when a service is not considered medically necessary, appropriate, or because it is experimental or investigational. You will receive written notification to let you know if we have made an adverse determination. In the notice, you will receive detailed information about why the decision was made, as well as the process and time frame you should follow for submitting appeals.

Member Resources & Rewards



Visit us online at
Ambetterofillinois.com

Our website helps you get the answers you need to get the right care, the right way, including an online member account for you to check the status of your claim, view your *Evidence of Coverage (EOC)* or understand your out-of-pocket costs, copays and progress towards meeting your annual deductible.

Get Online And Get In Control

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

On our website, you can:

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

Log into your online member account to:

- Pay your monthly bill
- Print a temporary ID or request a replacement ID
- View your claims status and payment information
- Change your PCP
- Find pharmacy benefit information
- Send us a secure email
- Read your member materials (your *Evidence of Coverage*, *Schedule of Benefits*, this QRG)
- Participate in the *myhealthpays*[®] rewards program
- Complete your Wellbeing Survey
- Contact a nurse online
- Review out-of-pocket costs, copays and progress towards deductibles.

myhealthpays[®] Rewards Program

Don't miss out on the exciting *myhealthpays*[®] program and start earning points today!

Log in now and activate your account to start earning more rewards.

1. Log into your online [Ambetter member account](#) or create your account now.
2. Click Rewards on the home page.
3. Accept Terms & Conditions. Then, start earning points!

If you already activated your account, log back in to complete healthy activities and keep earning!

Funds expire immediately upon termination of insurance coverage.

NEW OPTIONS FOR MANAGING YOUR DIGITAL MEDICAL RECORDS

Starting July 1, 2021, a new federal rule named the Interoperability and Patient Access rule (CMS-915-F) made it easier for Ambetter members to access their health information when they need it most. You will now have complete access to your health information on your mobile device which will allow you to manage your health better and know what healthcare resources are available to you.

Imagine:

- You go to a new healthcare provider because you don't feel well and pulling up your health history from the past five years on your mobile device.
- Finding a provider or specialist by checking an up-to-date provider directory who can use your health history to diagnose you and ensure you receive the best care you can.
- You have a question about a claim, so you go to your computer and see if it's paid, denied, or still being processed.
- Taking your health history data, at your request, with you as you move between health plans.*

**Beginning January 1, 2022, members will have this ability to request that their health information be transferred with them as they move between health plans.*

THE NEW RULE MAKES IT SO YOU CAN EASILY FIND INFORMATION** ON:

- Claims (paid and denied)
- Specific parts of your clinical information
- Pharmacy drug coverage
- Healthcare providers

***Information is available for dates of service on or after January 1, 2016*

For more information, visit your Ambetter online member account.

Your Healthcare Glossary

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

Adverse Determination Notice

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

Appeal

An Appeal is a request to reconsider a decision about the member's benefits where either a service or claim have been denied. A denial includes a request for us to reconsider our decision to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to, or continued stay in, a health care facility. Failure to approve or deny a prior authorization request timely may be considered as a denial and also subject to the appeal process.

Complaint

A complaint can be an appeal or a grievance. Some complaints can be resolved through first call resolution if they can be fully addressed and closed.

Copay or Copayment

The set amount of money you pay every time you receive a medical service or pick up a prescription.

Emergency Care/Emergencies

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

Evidence of Coverage

The document that lists all of the services and benefits that your particular plan covers. Your *Evidence of Coverage* has information about the specific benefits covered and excluded under your health plan. Read through your *Evidence of Coverage* — it can help you understand exactly what your plan does and doesn't cover.

Grievance

Any complaint about quality of service or medical care is a grievance, including dissatisfaction with the quality of medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

In-Network (Providers and/or Services)

The Ambetter network is the group of providers and hospitals we partner with to provide care for you. If your provider or service is within our network, it is covered on your health plan. If a provider or service is out-of-network, you could be responsible for services you receive. When possible, always stay in-network.

Inquiry

A request for clarification of a benefit, product, or eligibility where no expression of dissatisfaction was made.

For a full list of complete definitions, please refer to your *Evidence of Coverage*.



Your Healthcare Glossary (Continued)

Out-of-Network Provider

Means a physician or provider who is NOT identified in the most current list for the network shown on your Member ID. Services received from an out-of-network provider are not covered, except as specifically stated in your *Evidence of Coverage* (EOC). Refer to your *Evidence of Coverage* for details regarding out-of-network providers, care, services and expenses.

Premium Payment

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

Preventive Care Services

Preventive care services are regular healthcare services designed to keep you healthy and catch problems before they start. For example: your checkups, blood pressure tests, certain cancer screenings and more. A list of Preventive Care services can be found within your *Evidence of Coverage*, as well as on our website at AmbetterofIllinois.com.

Primary Care Provider (PCP)

Your PCP is the main doctor you will see for your healthcare needs. Get to know your PCP well and always stay up-to-date with your well-visits. The better your PCP knows your health, the better they are able to serve you.

Prior Authorization

Prior authorization may be required for covered services. When a service requires prior authorization, then the covered service needs to be approved before you visit your provider. Your provider will need to submit a prior authorization request.

Schedule of Benefits

Your *Schedule of Benefits* is a document that lists covered benefits available to you. Your *Schedule of Benefits* has information about your specific copayment, cost sharing and deductible amounts for covered benefits.

Subsidy

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

Urgent Care

Urgent care is medical care that you need quickly. You can get urgent care at an urgent care center.

Utilization Management

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

Ambetter of Illinois is insured by Celtic Insurance Company.
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Statement of Non-Discrimination

Ambetter of Illinois Insured by Celtic Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Ambetter of Illinois at 1-855-745-5507 (TTY 1-844-517-3431).

If you believe that Ambetter of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Ambetter of Illinois, Attn: Appeals and Grievances, PO Box 10341 Van Nuys CA, 91410, 1-855-745-5507 (TTY 1-844-517-3431), Fax 1-833-886-7956. You can file a grievance by mail or fax. If you need help filing a grievance, Ambetter of Illinois insured by Celtic Insurance Company is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter of Illinois insured by Celtic Insurance Company, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Polish:	Jeżeli ty lub osoba, której pomagasz, macie pytania na temat Ambetter of Illinois insured by Celtic Insurance Company, macie prawo poprosić o bezpłatną pomoc i informacje w języku ojczystym. Aby skorzystać z pomocy tłumacza, zadzwoń pod numer 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter of Illinois insured by Celtic Insurance Company 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-855-745-5507 (TTY/TDD 1-844-517-3431)。
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter of Illinois insured by Celtic Insurance Company 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-855-745-5507 (TTY/TDD 1-844-517-3431) 로 전화하십시오.
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter of Illinois insured by Celtic Insurance Company, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter of Illinois insured by Celtic Insurance Company ، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter of Illinois insured by Celtic Insurance Company вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Gujarati:	જે તમને અથવા તમે જેમની મદદ કરી રહ્યા હોય તેમને, Ambetter of Illinois insured by Celtic Insurance Company વપશો કોઈ પ્રશ્ન હોય તો તમને, કોઈ ખર્ચ વગર તમારી ભાષામાં મદદ અને માહિતી પ્રાપ્ત કરવાનો અધિકાર છે. દુભાવણ્યા સાથે વાત કરવા માટે 1-855-745-5507 (TTY/TDD 1-844-517-3431) ઉપર કોલ કરો.
Urdu:	اگر Ambetter of Illinois insured by Celtic Insurance Company کے بارے میں آپ، یا جن کی آپ مدد کر رہے ہیں ان کے سوالات ہوں تو، آپ کو بلا معاوضہ اپنی زبان میں مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی مترجم سے بات کرنے کے لیے، 1-855-745-5507 (TTY/TDD 1-844-517-3431) پر کال کریں۔
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter of Illinois insured by Celtic Insurance Company, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Italian:	Se lei, o una persona che lei sta aiutando, avesse domande su Ambetter of Illinois insured by Celtic Insurance Company, ha diritto a usufruire gratuitamente di assistenza e informazioni nella sua lingua. Per parlare con un interprete, chiami l'1-855-745-5507 (TTY/TDD 1-844-517-3431).
Hindi:	आप या जिसकी आप मदद कर रहे हैं उनके, Ambetter of Illinois insured by Celtic Insurance Company के बारे में कोई सवाल हों, तो आपको बिना किसी खर्च के अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। किसी दुभाषिये से बात करने के लिए 1-855-745-5507 (TTY/TDD 1-844-517-3431) पर कॉल करें।
French:	Si vous-même ou une personne que vous aidez avez des questions à propos d'Ambetter of Illinois insured by Celtic Insurance Company, vous avez le droit de bénéficier gratuitement d'aide et d'informations dans votre langue. Pour parler à un interprète, appelez le 1-855-745-5507 (TTY/TDD 1-844-517-3431).
Greek:	Εάν εσείς ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με την Ambetter of Illinois insured by Celtic Insurance Company, έχετε το δικαίωμα να ζητήσετε βοήθεια και πληροφορίες στη γλώσσα σας, χωρίς χρέωση. Για να μιλήσετε με διερμηνέα, καλέστε το 1-855-745-5507 (TTY/TDD 1-844-517-3431).
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter of Illinois insured by Celtic Insurance Company hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-745-5507 (TTY/TDD 1-844-517-3431) an.