# 2022 AmeriBen Annual Member Communication

We would like to share some important information regarding the AmeriBen Utilization Management services available to you through your health plan. Utilization management (UM) is a process that helps members get the right care in the right place. This process helps us decide if certain outpatient care, inpatient hospital care or procedures are medically necessary. UM also helps to determine if the services will be covered by the members' health plan.

## Pre-certification and Clinical Guidelines/ Medical Policies

We are committed to providing quality care and services to the members we serve. AmeriBen Medical Management uses clinical criteria and guidelines to approve, change or to deny the requested care for people with similar illnesses or conditions. Utilization management decisions are based only on appropriateness of care and service and existence of coverage, and AmeriBen does not reward denials of coverage. Decisions are based on what is right for each member based on the type of care and service. We look for standards that are taken from:

- Medical policies
- Nationally recognized clinical guidelines
- Your health benefits

Your pre-certification letter will indicate which clinical guideline and/ or medical policy was used for your pre-certification request. Medical policies address the medical need for new services or procedures and new applications of existing services or procedures. If a medical policy was used in your pre-certification, those can be accessed at MyAmeriben.com. Also, if an MCG guideline was used in your pre-certification, you can get a free copy of the MCG Guideline used by calling AmeriBen Medical Management.

## Want to learn more about our UM process?

**Call us toll free. Monday - Friday, 8:00 am - 5:00 pm MST at 800-388-3193**

If you call after normal business hours, you can leave a private message. Our staff will return your call the next business day. Calls received after midnight will be returned the same business day. Keep reading to learn how to get help in your preferred language.

## Want to contact us but not in English?

Free language help is available.

No matter what your preferred language is, our free interpretation service can help. Just call the Customer Service number on your ID card and ask for translation services in your preferred language. You can also ask for the translation of some written materials about your benefits.

TTY/TDD services are also available by dialing 711 or by contacting Customer Care. A special operator will contact us to help with your needs.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número telefónico de Atención a clientes que se encuentra en su tarjeta de identificación de miembro o en el folleto de inscripción.

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# Looking for information about your plan?

Every year, we share details about your benefits and rights and responsibilities as a member so you can get the most from your health plan. This information is online, all in one place, and available anytime. **Visit MyAmeriBen.com to:**

## Learn how to:

- Access primary and specialty care, behavioral health and hospital services.
- Access care when you are out of the plan's service area.
- Get information about accessing emergency care and when to use 911 services.
- Search for doctors, specialists or hospitals in our network and learn about their qualifications.
- Find a new doctor if you are turning 18 and ready to move to adult care.
- File a claim for covered services.
- Access care after normal office hours.
- Voice a complaint or appeal a decision. This includes your right to independent external appeal.
- Get translation services in your preferred language and access TTY/TDD services.
- Share information about all the care you get with all your doctors.
- Keep yourself healthy with preventive care services.

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## Learn about important programs:

- Utilization management (UM) process, rules for decision makers, how to contact UM staff toll-free, and our hours of operation.
- Case management (CM) program and how to sign up if you have a serious medical condition.

## Learn about:

- Your rights and responsibilities.
- Covered and non-covered services and benefits that have limitations.
- Copayments and any costs you may have to pay.
- Steps we take when evaluating new treatments to be considered as covered benefits.

### Help to resolve your concern, appeal a decision, or file a complaint

If you have a concern, or if you want to appeal a coverage or non-coverage decision we have made, you can use the complaint and appeals process to help you get your concern resolved fairly. Follow these key steps. Some of these steps must happen within a certain time frame.

**Step 1:** Call or write to Customer Service. We will do our best to resolve your concern, answer your question about the appeals process, or address your complaint fairly and quickly.

**Step 2:** You can file an appeal. Customer Service will tell you how and let you know about any steps you must take within a certain time frame.

**Step 3:** If step 2 does not resolve your concern, you may be able to appeal further. If your plan offers a second level appeal, we will let you know of any specific state rules or requirements and if there are other steps you can take.

**Step 4:** In some cases, if benefits are denied at the final internal appeal level, you may have the right to ask for an independent external review. You can find more details about the complaint and appeals process by calling the Customer Service number or the pre-certification number on your member ID card.