

Member Support Services and Benefits



CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care, and to encourage appropriate use of available services. We are always happy to work in partnership with you to meet the health care needs of our members.

New Member Identification Cards and Kits — Medicaid

Each new member household receives a new member kit, a welcome letter, and an ID card for each person in the family who has joined CareSource. The new member kits are mailed separately from the ID card and new member welcome letter.

New Member Kit Contains:

- A current provider directory that lists health care providers and facilities participating with CareSource
- A member handbook which explains plan services and benefits and how to access them
- A health assessment survey
- CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information

New Member Kits — Medicare

Each new member, at the time of enrollment, receives the following information/documents:

- Introductory Cover Letter
- Summary of Benefits (SOB)
- Evidence of Coverage (EOC)
- Abridged Formulary
- Provider Directory
- Pharmacy Directory
- LIS Rider

Following the initial enrollment process, the member receives the following:

- Initial acknowledgement letter
- CMS confirmation letter
- Identification card

Member Services — Medicaid

CareSource provides assistance to members with questions or concerns about services or benefits. Member Services Representatives are available to members by telephone Monday through Friday, 8 a.m. to 5:30 p.m., except on holidays. Members can access Member Services by calling our toll-free phone number, **1-800-390-7102** (TTY for the hearing impaired: 1-800-649-3777 or 711). Members are encouraged to call for assistance.

Member Services — Medicare

CareSource Advantage assists Special Needs Plan (SNP) members and potential enrollees with questions or concerns about services, benefits, and enrollment by telephone Monday through Friday, 8 a.m. to 8 p.m. Members access Member Services by calling our toll-free phone number, **1-877-725-4581** (TTY for the hearing impaired: 1-800-649-3777 or 711).

CareSource 24 — For All Health Plans

Members can call our URAC accredited nurse triage line 24 hours a day, seven days a week. With CareSource 24, members have unlimited access to talk with an experienced staff of Registered Nurses about symptoms or health questions. Nurses assess members' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct members to the most appropriate place for treatment. Schmitt-Thompson is the "Gold Standard" in telephone triage, offering evidence-based triage protocols and decision support. CareSource 24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider by explaining the importance and the role of the Primary Care Provider (PCP) in coordinating the member's care.

Members can call our URAC accredited nurse triage line 24 hours a day, seven days a week. With CareSource 24, members have unlimited access to talk with an experienced staff of Registered Nurses about symptoms or health questions.

Key features of this service include nurses who:

- Assess member symptoms
- Advise of the appropriate level of care
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCP-member relationship

Medicaid Members can access CareSource 24 by calling our toll-free phone number, **1-866-206-0488** (TTY for the hearing impaired: 1-800-649-3777 or 711).

CareSource Advantage Members can access CareSource 24 by calling our toll-free phone number, **1-866-206-0437** (TTY for the hearing impaired: 1-800-649-3777 or 711).

Disease Management/Case Management/Outreach

CareSource provides disease management, case management and outreach to Medicaid and Medicare members to support the physician's plan of care, educate them about their conditions, remind them of important well-care services and provide information about their benefits with CareSource.

Case management is provided by Case Managers who are nurses or social workers. The Case Managers provide one-to-one, personal interaction with members who are medically complex. Case management activities support the primary care provider (or treating physician) and member. The goal of case management is to improve the overall health and quality of life of the member. The Case Manager conducts a health assessment of all members and establishes goals with the members based on needs identified. Education of members, coordination of services, and identification of community and other resources to assist the member are services provided by case management on an individual basis. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Case management can be especially effective for encouraging non-compliant patients, reinforcing medical instructions, and assessing social needs.

All CareSource Advantage members are enrolled in case management and the health assessment is completed within 90 days of their effective date with CareSource Advantage.

Our focused case management programs include, but are not limited to:

- Persons with Special Health Care Needs
- Asthma
- Congestive Heart Failure
- Diabetes
- Pregnancy
- Weight Management
- Care Transitions

We also offer education and support for many diseases through disease management programs. These include asthma, diabetes, hypertension, congestive heart failure, chronic obstructive pulmonary disease and tobacco cessation. Disease management components include population identification, member education including primary prevention, behavior modification and compliance.

CareSource provides disease management, case management and outreach to Medicaid and Medicare members to support the physician's plan of care, educate them about their conditions, remind them of important well-care services and provide information about their benefits with CareSource.

Outreach activities provide services beyond conventional models. Health care specialists provide a welcome call with all new members. Periodic outreach calls to members focus on reminders to obtain preventive services like lead screening, immunizations, well child check-ups, well-adult check-ups, postpartum visit and more. These calls include information about healthy lifestyles including emergency room use, health risk assessment follow-up, assessment of readiness to change, weight management and tobacco cessation. Our focus is directed at helping our members acquire and maintain effective management of their condition, assure their satisfaction with their medical care, minimize inappropriate emergency room utilization, decrease hospitalizations and support your care and treatment of your patient through assessment, coordination of care, education and support.

Please contact us at **1-800-390-7102** and follow the prompts if you identify any CareSource member at risk who may benefit from disease management or case management services. We appreciate your active participation in the development of care/treatment plans.

Emergency Department Diversion Program — CareSource is committed to making sure our members access the most appropriate health care services for their needs. Member Emergency Room (ER) utilization is tracked closely. When there is frequent ER utilization, members are referred to our Case Management and Outreach Department for analysis or intervention. We educate our members on how to determine the level of care they should access for their condition and provide assistance in removing any identified health care access barriers. Members are informed to call 911 or go to the nearest ER if they feel they have an emergency. We instruct members to call their Primary Care Provider (PCP) or CareSource 24 if they are unsure if they need to go to an emergency room. CareSource covers all emergency services for our members. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Prenatal Case Management — CareSource has a program for prenatal and neonatal case management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. The expertise offered by the staff includes a focus on educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also identify and encourage the use of local resources, such as the Maternal Infant Health Program (MIHP) and Women, Infant and Children (WIC) programs. We encourage our prenatal care providers to notify our case management department when a member with a high-risk pregnancy has been identified.

*Please contact us at
1-800-390-7102 and
follow the prompts if you
identify any CareSource
member at risk who may
benefit from disease
management or case
management services.*

Member Services and Programs — Medicaid

Babies First Program

Pregnant members and new mothers can earn up to \$110 in gift cards to local stores by receiving recommended prenatal care for themselves and preventive well child care for their children through age 15 months. Members and providers can obtain Babies First brochures and coupons from CareSource. Each coupon contains instructions, for example, keeping all scheduled prenatal appointments during a given trimester. Once the instructions on the coupon have been completed, members then mail the coupons to CareSource to receive gift cards for complete and verified coupons. If you provide OB or preventive services, CareSource members may ask you to validate coupons by completing information on the back of the coupon and signing where indicated.

Pregnant members and new mothers can earn up to \$110 in gift cards to local stores by receiving recommended prenatal care for themselves and preventive well child care for their children through age 15 months.

Help To Quit Smoking

CareSource knows it is hard to quit smoking. We're here to help. We offer the Michigan Tobacco Quitline, an American Cancer Society program, for our Medicaid members. The Michigan Tobacco Quitline is free to our members. It is a telephone coaching service to help tobacco users who are trying to quit. The Quitline is answered 24 hours a day, seven days a week.

We offer the Michigan Tobacco Quitline, an American Cancer Society program, for our Medicaid members.

How Quitline Works

- The CareSource member calls the Michigan Tobacco Quitline at **1-800-QUIT-NOW (1-800-784-8669)**.
- The member can choose to have a one-time session to help him/her plan how to quit on their own, or they can enroll in a five-session coaching program. If they choose the coaching program, they are assigned a coach to help them. They will have the same coach help them through the program. The member picks the best day and times for the coaching sessions. The coach calls them.
- They will also receive free printed information through the mail. It provides suggestions on how to cope with temptations to smoke.

Nicotine Replacement Therapy

CareSource covers nicotine replacement therapy such as nicotine gum or patches, or medications like Zyban or Wellbutrin. A prescription from the member's physician is required:

- Patch — Over the counter covered with prescription for 90 days/year
- Gum — Over the counter covered with prescription for 90 days/year
- Lozenge — Over the counter covered with prescription for 90 days/year
- Inhaler — Requires prior authorization (must have tried over the counter or generic first)
- Nasal spray — Requires prior authorization (must have tried over the counter or generic first)
- Bupropion or Wellbutrin — Covered with prescription; no prior authorization required
- Chantix / Varenicline — Requires prior authorization (must have tried over the counter or generic first)

CareSource covers nicotine replacement therapy such as nicotine gum or patches, or medications like Zyban or Wellbutrin.

Eyeglass Frames

For all vision services including eye exams, CareSource members should contact Vision Services Plan (VSP) at **1-800-877-7195**.

Services for members under the age of 21 include:

- One complete eye exam every two years
- One pair of prescription lenses and eyeglass frames every two years. Many frames are covered in full.
- Replacement glasses. Members who lose or break their glasses may be able to get another pair.

Services for members age 21 and older include:

- One complete eye exam a year
- One pair of prescription lenses and eyeglass frames every two years. Many frames are covered in full.

*For all vision services including eye exams, CareSource members should contact Vision Services Plan (VSP) at **1-800-877-7195**.*

Eyeglass Frames — Medicare

Members of our health plan can choose from a large selection of eyeglass frames. CareSource covers up to \$50 for eyewear every two years. Please see the Specialty Care Providers section in this manual for more details.

Transportation — Medicaid

Transportation can be provided for members' medical appointments with participating and approved providers. It is arranged for those members who qualify for transportation assistance, and the type of transportation is based upon the member's needs and medical condition. The transportation benefit for Medicaid is limited to 20 round trip medical visits per member per 12-month period. Additional trips may require prior authorization from the transportation vendor.

Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Services phone number on their ID card and selecting the option for transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

The transportation benefit for Medicaid is limited to 20 round trip medical visits per member per 12-month period.

Transportation — Medicare Advantage

Transportation can be provided for a member's medical appointments with appropriate providers. The transportation benefit for Medicare Advantage is limited to 30 roundtrips per member per calendar year.

Transportation is provided at no cost to the member. Members can arrange transportation by calling the Member Service number on their ID card and selecting the option for transportation. Members receive information upon enrollment that indicates how far in advance they need to make arrangements.

The transportation benefit for Medicare Advantage is limited to 30 roundtrips per member per calendar year.

Health Education

CareSource members receive health information from CareSource through a variety of communication vehicles including easy-to-read newsletters, brochures, phone calls and personal interaction. CareSource also sends preventive care reminder messages to members via mail and telephone.

Interpreter Services — Medicaid/Medicare

(Non-Hospital Providers Only)

CareSource offers sign and language interpreters for members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability. These services are available at **no cost** to the member or health care provider. As a provider you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately.

To arrange services, please contact Provider Services at **1-800-390-7102** (TTY for the hearing impaired: 1-800-649-3777 or 711). We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

CareSource offers sign and language interpreters for members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability.

Interpreter Services — Medicaid/Medicare *(Hospitals Only)*

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability. These services should be available at **no cost** to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Provider Services at **1-800-390-7102** (TTY for the hearing impaired: 1-800-649-3777 or 711). We ask that you let us know of members in need of interpreter services as well as any members that may receive interpreter services through another resource.

Member Rights and Responsibilities — Medicaid

As a CareSource provider you are required to respect the rights of our members. CareSource members are informed of their rights and responsibilities via their member handbook. The list of our member's rights and responsibilities are listed below.

All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights, as stated in the member handbook, are as follows:

- To receive information about CareSource, our services, our practitioners and providers and member rights and responsibilities.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information is kept private.
- To say yes or no to having any information about you given out unless CareSource has to by law.

- To be given information about your health. You can ask your PCP for your medical records.
- You can also ask CareSource for information.
- To get information on any appropriate or medically necessary treatment options for your condition, regardless of cost, or benefit coverage.
- To get information on any medical treatment option from your provider, whether or not it is covered by CareSource.
- To get written materials in alternative formats if you have special needs.
- To take part in decisions about your health care unless it is not in your best interest.
- To be sure that others cannot hear or see you when you are getting medical care.
- To get an interpreter if you do not speak or understand the language of your provider.
- You can have an interpreter with you during a medical exam. This is a free service.
- To ask if CareSource has special payment arrangements with providers that could affect services you may need or receive. Please call our service center to get this information.
- To say no to treatment or therapy to the extent allowed by law. If you refuse care, you are responsible for what could happen as a result.
- To file a grievance (complaint) or appeal or to request a state hearing.
- To get medical care regardless of race, color, religion, sex, sexual orientation, disability, national origin, veteran's status, ancestry, health status or need for health services.
- To make recommendations regarding CareSource's member rights and responsibilities policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Michigan Department of Community Health Bureau of Civil Rights at the following addresses 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.

Office of Civil Rights

U.S. Dept. of Health and Human Services
 105 W. Adams, 16th Floor
 Chicago, Illinois 60603
 (312) 886-2359
 (312) 353-5693 TTY

Michigan Department of Community Health

Medical Services Administration
 P.O. Box 30470
 Lansing, MI 48909-9753
 1-800-642-3195

Members may contact CareSource for information about:

- The structure and operation of CareSource
- How CareSource pays health care providers
- How CareSource works with other health plans if a member has other health care coverage
- Results of member surveys
- CareSource member disenrollment rates
- Benefits, eligibility, claims or participating health care providers

Members are also informed of the following member responsibilities:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time, and if they have to cancel, call 24 hours in advance. If you have scheduled transportation to your doctor appointment, please cancel the transportation request as well.
- Follow the advice and instructions for care they have agreed upon with their doctors and other health care providers.
- Always carry their CareSource ID card and do not let anyone else use their ID card.
- Notify their county caseworker and CareSource of a change in their telephone number or address.
- Notify CareSource of the number of people in your family and if there is a change in that number, such as a baby being born or a family member moving out.
- Contact their PCP after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Use emergency room services only when you believe an injury or illness could result in lasting death or injury.
- Let us know if any member of their family has other health insurance coverage.
- Provide the information that CareSource and their health care providers need in order to provide care for them.
- Understand as much as possible about their health issues and take part in reaching goals that they and their health care provider agree upon.
- Consult our member website (www.caresource.com) for any updates to member rights and responsibilities.

HIPAA Notice of Privacy Practices — Members are notified of CareSource's privacy practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CareSource's Notice of Privacy Practices includes a description of how and when member information is used and disclosed within and outside of the CareSource organization. The notice also informs members on how they may obtain a statement of disclosures or request their medical claim information. CareSource takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of members.

As a provider, please remember to follow the same HIPAA regulations as a covered entity and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Member Rights and Responsibilities — Medicare Advantage

CareSource Medicare members' rights and responsibilities as stated in the Evidence of Coverage are:

Our plan must honor your rights as a member of the plan

- ▶ ***We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area, in Braille, in large print, or other alternate formats, etc.)***

To get information from us in a way that works for you, please call Member Services. Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it.

If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

- ▶ ***We must treat you with fairness and respect at all times***

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY: 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

- ▶ ***We must ensure that you get timely access to your covered services and drugs***

As a member of our plan, you have the right to choose a Primary Care Provider (PCP) in the plan's network to provide and arrange for your covered services. Call Member Services to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, please refer to the Evidence of Coverage.

► ***We must protect the privacy of your personal health information***

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

- You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.
- You have the right to know how your health information has been shared with others for any purposes that are not routine.
- If you have questions or concerns about the privacy of your personal health information, please call Member Services.

► **We must give you information about the plan, its network of providers, and your covered services**

As a member of our plan, you have the right to get several kinds of information from us. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services:

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Provider Directory.
 - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
 - For more detailed information about our providers or pharmacies, you can call Member Services or visit www.caresource.com.
- **Information about your coverage and rules you must follow in using your coverage.**
 - The Evidence of Coverage explains what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see the Evidence of Coverage plus the plan's *List of Covered Drugs (Formulary)*. These documents together, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services.
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see the Evidence of Coverage. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (The Evidence of Coverage also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see the Evidence of Coverage.

► ***We must support your right to make decisions about your care***

You have the right to know your treatment options and participate in decisions about your health care. You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The Evidence of Coverage tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Michigan Bureau of Health Professions.

► You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, the Evidence of Coverage tells what you can do. It gives the details about how to deal with all types of problems and complaints. As explained in the Evidence of Coverage, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services.

► **What can you do if you think you are being treated unfairly or your rights are not being respected?**

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program**.
For details about this organization and how to contact it, go to the Evidence of Coverage.

► **How to get more information about your rights**

There are several places where you can get more information about your rights:

- You can **call Member Services**
- You can **call the State Health Insurance Assistance Program**
- You can contact **Medicare**
 - You can visit the Medicare website (<http://www.medicare.gov>) to read or download the publication "Your Medicare Rights & Protections."
 - Or, you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan

► **What are your responsibilities?**

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services. We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - The Evidence of Coverage gives details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - The Evidence of Coverage gives details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.**
Please call Member Services to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you with it.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and Medicaid card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a co-payment (a fixed amount) or co-insurance (a percentage of the total cost). The Evidence of Coverage tells what you must pay for your medical services. The Evidence of Coverage tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- **Tell us if you move.** If you are going to move, it’s important to tell us right away. Call Member Services.
 - **If you move outside of our plan service area, you cannot remain a member of our plan.** We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move within our service area, we still need to know** so we can keep your membership record up-to-date and know how to contact you.

- Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are on the front page of the Evidence of Coverage.
 - For more information on how to reach us, including our mailing address, please see the Evidence of Coverage

HIPAA Notice of Privacy Practices — Members are notified of CareSource’s privacy practices as required by the HIPAA. This notice includes a description of how and when medical information about CareSource members is used or disclosed and how members can access it. CareSource takes measures across our organization internally to protect oral, written and electronic personal health information of members.

Please remember that disclosures of a patient’s personal health information are permitted for treatment, payment or health-care operations in compliance with the HIPAA regulation 45 CFR 164. For example, health care providers may disclose patient information to CareSource for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others. Thank you for your assistance in providing requested information to CareSource in a timely manner.

Member Grievance and Appeals Procedures — Medicaid

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or providers, when designated as the authorized representative, may file grievance or appeals with CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members or providers can contact CareSource to learn more about these procedures.

Member Grievances — Any time a member informs us that they are dissatisfied with CareSource or a health care provider it is deemed a grievance by Michigan Department of Community Health (MDCH) and the Office of Financial and Insurance Regulation (OFIR). CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider’s office to gather information and attempt a possible resolution. CareSource responds to member grievances in accordance with OFIR and MDCH-mandated timeframes.

Member Appeals — CareSource notifies members in writing when we make a decision to deny a request to cover a service, reduce, suspend or stop care the member is already receiving, or do not pay for a service a member received that is not covered by CareSource. Members have the right to appeal the actions listed in the letter if they contact CareSource within 90 calendar days. CareSource responds to member appeals in accordance with OFIR and MDCH-mandated timeframes.

State Hearings — CareSource members can request a state hearing through MDCH if CareSource makes a decision to deny, reduce, suspend or stop care for a member. CareSource members can also request a state hearing if they receive a bill from a provider as a result of CareSource’s denial of payment.

If members would like a state hearing, they are asked to sign and return a state hearing form within 90 days of the mailing date on the form. CareSource will assist the member with filing this action, if needed. If CareSource proposes to reduce, suspend or terminate a service already approve. Members may request continuation of benefits during a state hearing. However, MDCH may hold the member liable for the cost. Health care providers have the right to participate in the state hearing process if the member has authorized them to act as their authorized representative or requested that the provider attends as a witness. A hearing officer will consider the case and render a determination based upon information presented and whether state regulations were followed. At any time during this process, members may contact MDCH.

External Review — In addition to a state hearing, CareSource members may ask for an independent review by OFIR if CareSource decides not to approve medical care that has been requested for them. These reviews are conducted by a certified medical review organization instead of CareSource. Members must exhaust CareSource’s appeal process first and request the independent review in writing within 60 days of the date CareSource notifies them of the appeal denial. CareSource’s Member Services Department can explain the independent review process.

Member Grievance and Appeals Procedures — Medicare

Member Grievances — Any time a member informs us that they are dissatisfied with CareSource or a health care provider, it is a grievance. A grievance may include any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which CareSource or our delegated entity provides health care services. An expedited grievance may also include a complaint that CareSource refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievances may also include complaints that covered health service procedure or items during a course of treatment that did not meet accepted standards of delivery or health care. CareSource investigates all grievances. If the grievance is about a provider, CareSource calls the provider’s office to gather information and attempt a possible resolution. CareSource responds to member grievances in accordance with CMS timeframes.

Member, Provider or Provider Appealing on Behalf of a Member Standard Medical Necessity Appeals of Non-Certification Determinations

For appeals on behalf of the member please refer to the CareSource Advantage Member's Evidence of Coverage. The Evidence of Coverage is located on www.caresource.com. Search "Evidence of Coverage."

Level 1: Appeal – Reconsideration

A member starts the appeal process by making an appeal. It is called the first level of appeal or a Level 1 Appeal.

The member contacts CareSource and makes the appeal. If their health requires a quick response, they must ask for a fast appeal. To start an appeal the member, their representative, or in some cases their doctor must contact CareSource. Appeal request must be within 60 calendar days from the date on the written notice sent concerning a coverage decision. If the member wishes, their doctor may give additional information to support the appeal.

A standard appeal must be in writing and must be completed within 30 calendar days after being received by CareSource.

A fast appeal is also called an expedited appeal. An expedited appeal can be a verbal or written request and must be completed within 72 hours after being received by CareSource

Level 2: Independent Review Entity – IRE

If CareSource says no to the Level 1 Appeal, the case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision made during the first appeal. This organization decides whether the decision made should be changed.

Step 1: The Independent Review Organization reviews the appeal. The Independent Review Organization is an outside independent organization that is hired by Medicare. This organization is not connected with CareSource and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. CareSource will send information about the appeal to this organization. This information is called the "case file." The member has the right to ask for a copy of the case file. The member has a right to give the Independent Review Organization additional information to support their appeal. Reviewers at the Independent Review Organization will take a careful look at all of the information related to the appeal.

If there was a "fast" appeal at Level 1, there will also be a "fast" appeal at Level 2.

Level 3: Administrative Law Judge – ALJ

The notice received from the Independent Review Organization will tell the member in writing if the case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage being requested must meet a certain minimum. If the dollar value of the coverage being requested is too low, the member cannot make another appeal, which means that the decision at Level 2 is final.

Level 4: The Medicare Appeals Council

The Medicare Appeals Council will review the member's appeal and give the member an answer. The Medicare Appeals Council works for the Federal government.

If the member's Level 4 appeal is approved, or if the Medicare Appeals Council denies CareSource's request to review a favorable Level 3 Appeal decision, the appeals process *may or may not* be over. CareSource will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), CareSource has the right to appeal a Level 4 decision that is favorable to the member. If CareSource decides *not* to appeal the decision, CareSource must authorize or provide the member with the service within 60 days after receiving the Medicare Appeals Council's decision. If CareSource decides to appeal the decision, CareSource will let the member know in writing.

If the member's Level 4 appeal is denied or if the Medicare Appeals Council denies the review request, the appeals process *may or may not* be over.

If the member decides to accept this decision, the appeals process is over. If the member does not want to accept the decision, the member might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to the member's appeal, the notice the member receives will tell the member whether the rules allow the member to go on to a Level 5 Appeal. If the rules allow the member to go on, the written notice will also tell the member who to contact and what to do next if the member chooses to continue with the next level of review.

Level 5: A Judge at the Federal District Court

A judge at the Federal District Court will review your appeal if permitted based on the Level 4 response. This is the last stage of the appeals process.