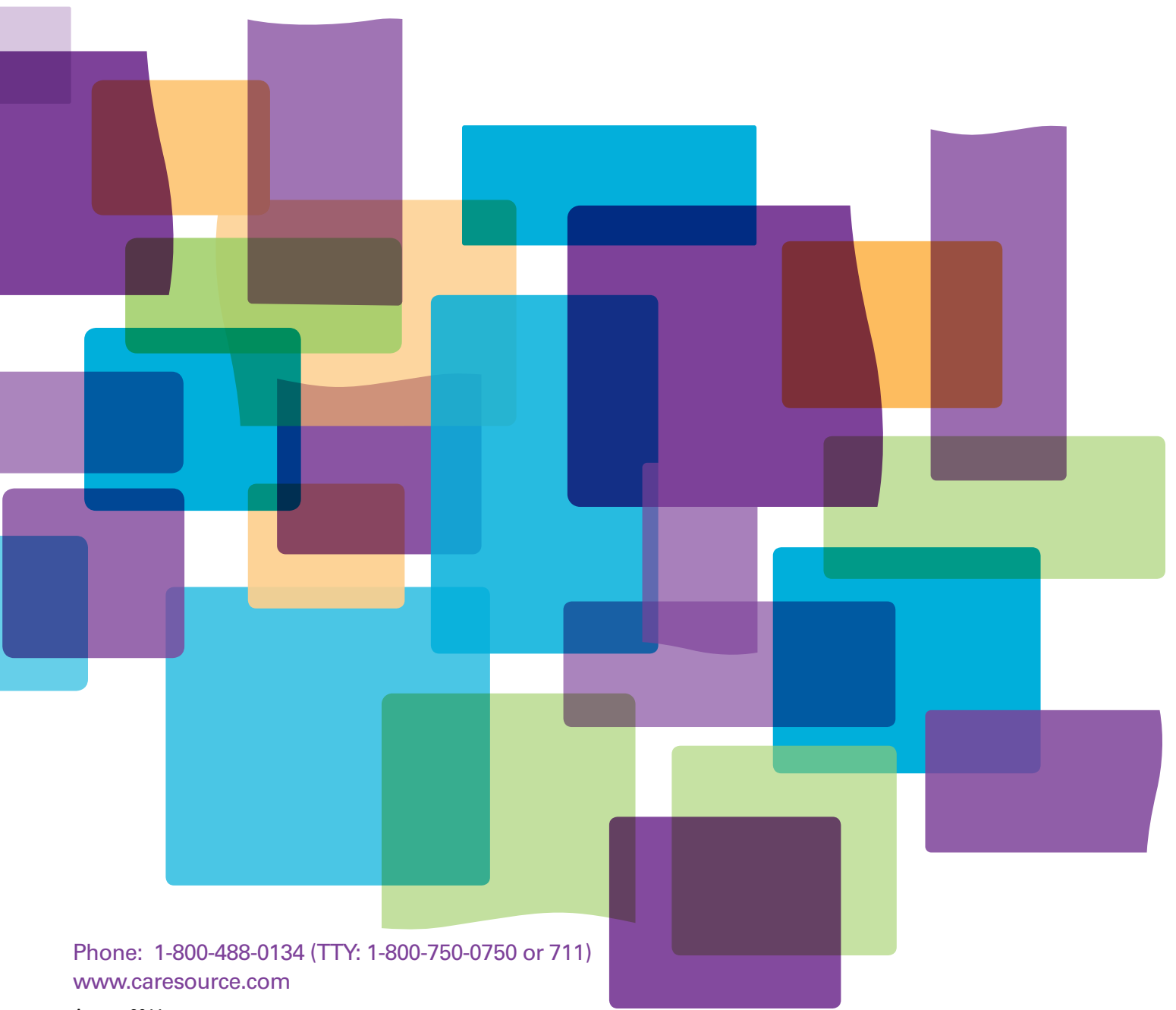




Member Handbook

Covered Families and Children



Phone: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)

www.caresource.com

August 2011

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*If you have any problems in reading or understanding this or any other CareSource information, please contact our Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for help at no cost to you. We can help to explain the information or provide the information orally, in English or in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing-impaired, special help can be provided.*

WELCOME

Welcome to CareSource.

You are now a member of a health care plan, also known as a managed care plan (MCP), for Covered Families and Children Medicaid consumers, including Healthy Start and Healthy Families.

Please read this handbook from cover to cover. It will answer many of the questions you might have. Or you can visit our website at **www.caresource.com**.

How To Reach Us

If you ever have a question or need to contact CareSource, please call us at:

1-800-488-0134 (toll free)
TTY for the hearing impaired:
1-800-750-0750 or 711

Follow the menu options to reach the Member Services Department. Your health and the health of your family is important to us. Please let us know if you ever have a question or concern about your health care or our services. We want you to be a healthy and happy member of CareSource.

We like to hear what you think of CareSource and we welcome your suggestions for better service. If you want to tell us about things you think we should change, please call the Member Services Department at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). Your ideas are important to us.



MEMBER SERVICES DEPARTMENT

Our Member Services Department is open Monday through Friday from 7 a.m. to 7 p.m., except on the holidays listed below. Our phone number is **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). Follow the menu

options to reach the Member Services Department. We are located at 230 N. Main Street in Dayton, Ohio. You can call, visit or e-mail us to:

- Ask questions about CareSource benefits, claims, eligibility, utilization management or prior authorization requests
- Find out what services are covered and how to access them
- Request a new member ID card
- Change your primary care provider (PCP)
- File a complaint about CareSource, a provider, or if you think you have been discriminated against
- Get help choosing a participating provider
- Let us know of changes to your address or phone number
- Access language assistance
- And more

Please give us a call. We want to make sure your concerns are taken care of and your questions are answered. We are not able to help you with these issues after 7 p.m. or on weekends or holidays. Have your member ID number handy when you call. This will help us serve you better.

If you need help after business hours, you can:

- Choose an option from our phone menu that meets your needs
- Send an e-mail at any time through our website. Just visit **www.caresource.com**

CareSource is closed on:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- The day after Thanksgiving
- The day before Christmas
- Christmas Day

A holiday that falls on a Saturday is observed on the Friday before it. One that falls on a Sunday is observed on the Monday after it.

NEW MEMBER INFORMATION

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

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

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

Interpreter Services

If there is a CareSource member in your family whose primary language is not English, is visually or hearing-impaired, or has limited reading skills, please call us to arrange interpreter services. We offer sign and language interpreters for members who need language assistance communicating with CareSource or their health care provider. By calling Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711), you can arrange to get interpreter services over the phone or in person. We can also provide some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. This is a free service to you.




CareSource

CARESOURCE 24 NURSE ADVICE LINE

With CareSource 24, you have unlimited access to talk with a caring and experienced staff of registered nurses through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource 24 services are available at no cost to you. Our nurses can help you:


- Decide when self-care, a doctor visit or the emergency room is appropriate
- Understand a medical condition or recent diagnosis
- Prepare questions for doctor visits
- Find out more about prescription or over-the-counter medicines
- Get information on medical tests or surgery
- Learn about nutrition and wellness topics

To reach CareSource 24, call **1-866-206-0554** (TTY: 1-800-750-0750 or 711).

IDENTIFICATION (ID) CARDS

You should have received a CareSource membership ID card. Each member of your family who has joined CareSource will receive their own card. Never let anyone else use your ID card. These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of CareSource. You will not receive a new card each month as you did with the Medicaid card.

If you are pregnant, you need to call CareSource when your baby is born so we can send you a new ID card for your baby.

		CareSource	CFC Member
Member Name	DATE	Date of Birth	
Mary Doe	SAMPLE	04-12-73	
CareSource Member ID #: 12345678900			
MMIS #: 987654321000		Case #: 7654321000	
Primary Care Provider/Clinic Name:			
Good, lam A.			
Provider/Clinic Phone: (937) 123-4567			
Member Services: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)			
24-hour nurse line: 1-866-206-0554 (TTY: 1-800-750-0750 or 711)			

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT VERIFY ELIGIBILITY.

MEMBER: Show your ID card to medical providers BEFORE you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER). If you are not sure if you need to go to the ER, call your primary care provider or call our 24-hour toll-free nurse advice line (see front of card for phone number).

HEALTH CARE PROVIDERS: You must verify member eligibility for the date of service. Visit www.caresource.com or call **1-800-488-0134** to access this information. Authorization required for inpatient admission.

MAIL MEDICAL CLAIMS TO: CareSource, P.O. Box 8730, Dayton, OH 45401-8730

PHARMACY: Providers call 1-800-488-0134

BENEFITS MANAGER: CVS Caremark

RxBIN 004336

RxPCN ADV

RxGRP RX0797

www.caresource.com

Always Keep Your ID Cards with You

You will need your ID card each time you get medical services. This means that you need your CareSource ID card when you:

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

We will need the member ID number on your card whenever you call our Member Services Department. This will help us serve you faster.

Call CareSource Member Services as soon as possible at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) if:

- You have not received your card(s) yet
- Any of the information on the card(s) is wrong

- You lose your card(s)
- You have a baby

A new card will automatically be mailed to you whenever you change your primary care provider.



YOUR PRIMARY CARE PROVIDER

Choosing a Primary Care Provider (PCP)

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

Your PCP will work with you to direct your health care. Your PCP will do your checkups and shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource ID card.

The Provider Directory in your membership kit is a list of doctors and other health care providers who accept CareSource members. If you haven't chosen a PCP yet, please choose one from the directory or call us to see if any new PCPs have been added to it recently. It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can. For the names of the PCPs in CareSource, you may look in your Provider Directory if you requested a printed copy, on our website at www.caresource.com, or you can call the

CareSource Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for help.

If you are a new patient to your PCP, please call the office to schedule an appointment. This will help your PCP get to know you and understand your health care needs right away. You should also have all of your past medical records transferred to your new doctor.

Changing Your PCP

We hope you are happy with the PCP you have chosen, but we know that you may decide to choose a different PCP in the future. If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. You can change your PCP as often as once a month, if needed. We will process your change the date of your call. CareSource will send you a new member ID card to let you know that your PCP has been changed and the date that you can start seeing the new PCP. Member Services can also help you schedule your first appointment, if needed.

For the names of the PCPs in CareSource, you may look in your Provider Directory if you requested a printed copy, on our website at www.caresource.com, or you can call the CareSource Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for help.

If your PCP tells us that he/she is moving away, retiring or leaving CareSource for any reason, we will assign another PCP for you and let you know by mail within 45 days whenever possible. You can call us if you need help choosing another PCP. We also inform you if any of our participating hospitals within your region quit participating.

Provider Directory

Our directory is subject to change. Some providers may have been added or removed since it was printed.

If you have a question or want to know which providers participate with CareSource, we can help. Just call our Member Services Department or visit our website at www.caresource.com. If you don't have access to our website, you can call Member Services to ask for a copy of our directory.



We can give you the most current information. And we can give you more details about providers when you call, if you want to know more. We want to make sure you are aware of all of your options.

DOCTOR APPOINTMENTS

Please schedule appointments with your doctor as far in advance as possible. It is important to keep your scheduled appointments. If you need to cancel or change appointments, please call the doctor's office at least 24 hours in advance. If you miss too many appointments, your doctor may ask that you choose another doctor.

The ODJFS requires that CareSource provide transportation to certain providers due to the location of their office. Please refer to your Provider Directory to determine which providers are affected by this requirement.

WHEN YOU CAN SEE A NON-PARTICIPATING PROVIDER

It is important to remember that you must receive services covered by CareSource from facilities and/or providers on CareSource's panel. See pages 8-12 for information on services covered by CareSource. The only time you can use providers that are not on CareSource's panel is for:

- Emergency services
- Federally Qualified Health Centers/Rural Health Clinics
- Certified nurse midwives or certified nurse practitioners
- Qualified family planning providers
- Community mental health centers
- Ohio Department of Alcohol and Drug Addiction Services facilities which are Medicaid providers
- An out-of-panel provider that CareSource has approved you to see

When you called the managed care enrollment center (MCEC) to select a managed care plan (MCP), you were asked whether you wanted provider panel information given to you as a printed Provider Directory or via the internet. If you asked for a printed directory, or did not contact the MCEC to enroll and were assigned to our plan, you should have also received a Provider Directory. The Provider Directory lists all of our panel providers as well as other non-panel providers you can use to receive services. If you want to use the internet, visit our website at www.caresource.com to view up-to-date provider panel information.



CareSource does not cover non-emergency services that happen outside the service area and after hours. If you have a non-emergent health need outside the service area after hours, call your PCP. You can also call CareSource 24, our nurse advice line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). We can help you.

In addition, your PCP may decide that you need medical care that you can only get from a doctor or other health care provider who is not participating with CareSource. If your PCP gets prior approval from CareSource for these services, they will be covered.

PREVENTIVE CARE IS IMPORTANT

Your PCP will play a big part in your preventive care. This means making regular visits to your doctor even if you do not feel sick. Routine checkups, tests and screenings can help your doctor find and treat problems early before they become serious. Preventive care includes:

- Immunizations for children
- Healthcheck exams for children from birth through age 20
- Yearly well-adult exams
- Pap smears
- Breast exams
- Regular dental and medical checkups

We have preventive health guidelines for:

- Men
- Women
- Pregnant women
- Babies and children

To access these and our clinical practice guidelines, please call Member Services at **1-800-488-0134**. Or visit our website at **www.caresource.com**.

WHERE TO GET MEDICAL CARE

We want to make sure you get the right care from the right health care provider when you need it. The following information will help you decide where you should go for medical care:

Is it safe to wait?

How to decide whether to go to an ER, urgent care or PCP

Ask yourself these questions:

- Is it safe to wait and call my doctor first?
- Is it safe to wait and schedule an appointment in the next day or two with my doctor?
- Is it safe to wait if I can get an appointment today with my doctor?
- If my doctor can't see me, is it safe to wait to be seen at an urgent care clinic as a walk-in?
- Could I die or suffer a serious injury if I don't get immediate medical help?

Remember, if you are not sure if your illness or injury is an emergency, call your doctor or CareSource 24. Just dial **1-866-206-0554** to talk to a CareSource 24 nurse.

Primary Care Services

You should see your PCP for all routine visits. Some examples of conditions that can be treated by your PCP are:

- Colds/flu
- Earache
- Backache
- Constipation
- Rash
- Sore throat
- Removal of stitches
- Headache
- Vaginal discharge
- Pregnancy tests
- Pain management

Urgent Care Centers

You can visit an urgent care center for non-emergency situations to keep an injury or illness from getting worse when your PCP's office is closed or if your PCP is not able to see you right away. If you think you need to go to an urgent care center, you can:



1. Call your PCP for advice.
You can reach your PCP, or a back-up doctor, 24 hours a day, seven days a week.

OR

2. Call CareSource 24, our nurse advice line, at **1-866-206-0554** (TTY: 1-800-750-0750 or 711).

OR

3. Go to a participating urgent care center listed in your Provider Directory or on our website at **www.caresource.com**. After you go, always call your PCP to schedule follow-up care.

If you need to go to an urgent care center while you are away from home and are out of the counties that CareSource covers, call your PCP or CareSource 24, our nurse advice line. They can help you decide what to do. If you go to an urgent care center, call your PCP as soon as you can to let him or her know of your visit.

Emergency Services

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

- Miscarriage/pregnancy with vaginal bleeding
- Severe chest pain
- Loss of consciousness
- Seizures/convulsions



- Uncontrolled bleeding
- Rape
- Severe vomiting
- Major burns

You do not have to contact CareSource for an okay before you get emergency services. If you have an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your primary care provider or the CareSource 24-hour nurse advice line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). Your PCP or the CareSource 24-hour advice line can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of CareSource and show them your ID card.
- If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call CareSource.
- If you are able, call your PCP as soon as you can to let him or her know that you have a medical emergency, or have someone call for you. Then call your PCP as soon as you can after the emergency to schedule any follow-up services.
- If the hospital has you stay, please make sure that CareSource is called within 24 hours.

SERVICES COVERED BY CARESOURCE

CareSource covers all medically necessary Medicaid-covered services. The services covered by CareSource are covered at no cost to you. You should not be billed for these services. If you receive a bill, please call us. Services covered by CareSource include the following:

Services That Do Not Require A Referral

The following services do not require a referral from your PCP. This means that your PCP does not need to arrange or approve these services for you. Just check your Provider Directory for a list of participating providers who offer these services and schedule an appointment yourself. If you are not sure what types of providers offer any of these services, please call CareSource for help.

Primary care provider services

You can make unlimited visits to the participating provider you choose as your PCP.

Yearly well-adult exams

Well-child (Healthchek) exams for children under the age of 21

Shots (immunizations)

Preventive mammogram (breast) and cervical cancer (Pap smear) exams

Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source

Prescription drugs, including certain prescribed over-the-counter drugs	Health care providers will write prescriptions for you that can be filled at a participating pharmacy. They are filled with generic drugs, when available, unless your provider gets prior approval for brand name drugs from CareSource. Please see the "Prescription Drugs" section of this handbook for more details.
Federally Qualified Health Center or Rural Health Clinic services	
Family planning services and supplies	You may receive services from your PCP or any obstetrician, gynecologist or qualified family planning provider listed in your Provider Directory such as Planned Parenthood.
Obstetrical (maternity care – prenatal and postpartum, including at-risk pregnancy services) and gynecological services	You may go to any participating Obstetrician or Gynecologist (OB/Gyn) listed in your Provider Directory.
Certified nurse midwife services	You may go to a certified nurse midwife (CNM). Check the Provider Directory or call CareSource for the names of available CNMs.
Certified nurse practitioner services	If you would like to see a certified nurse practitioner (CNP), check the Provider Directory or call CareSource for the names of available CNPs.
Emergency services	Please see "Where To Get Medical Care" on pages 7-8 for information on appropriate use of these services.
Mental health and substance abuse services	If you need mental health and/or substance abuse services, please call our Member Services Department at 1-800-488-0134 (TTY: 1-800-750-0750 or 711). Or you may self-refer directly to a community mental health center or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) facility which is a Medicaid provider. Please see your Provider Directory, call our Member Services Department or visit our website at www.caresource.com for the names and telephone numbers of the facilities near you.



You may go to any participating psychologist without a referral. You can make up to 25 visits per year without a referral or prior authorization. You need a referral from your PCP to see a psychiatrist except for those at community mental health centers. Please call us if you have questions.

Vision (optical) services, including eyeglasses

Routine checkups and services from optometrists, and eyeglasses, do not require a referral. Other services require a referral from your PCP or optometrist and/or prior authorization from CareSource.

Dental services

Good dental care is an important part of your health. You should visit your dentist for a routine dental exam every six months. These exams help catch problems early. Then you can get proper treatment to help correct any problems before they get worse. CareSource will pay for two dental exams every year. CareSource will also cover the following:

- X-rays
- Fillings
- Simple extractions
- Impacted tooth extractions
- General anesthesia
- Anterior (front teeth) root canals
- Healthchek screenings

CareSource may also pay for one set of full or partial dentures every eight years with prior authorization. Routine checkups and cleanings do not require a referral. We encourage you to get a checkup every six months. Some services may require a referral from your dentist and/or prior authorization from CareSource. Your dentist will take care of this for you. Please contact Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) if you have any questions regarding your dental benefit coverage.

Chiropractic (back) services

Members age 21 and older can have up to 15 visits per year without a referral. Members under 21 years of age may have up to 30 visits unless more are medically necessary as part of Healthchek services. Prior authorization may be required.

Podiatry (foot) services

Speech and hearing services

You can have up to 30 visits per year for speech therapy without a referral or prior authorization. Hearing exams do not require a referral or prior authorization. Members under 21 years of age may have more visits if medically necessary as part of Healthchek services. Prior authorization may be required.

Services for children with medical handicaps (Title V)

Services can be obtained from your PCP or from a specialist with a PCP referral.

Medical supplies

These require a prescription. Some supplies require a referral and/or prior authorization from CareSource.

Non-emergent transportation



Call CareSource to arrange transportation at:

1-800-488-0134

If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. CareSource also offers additional transportation services. This includes up to 30 one-way trips to medical visits, WIC and redetermination appointments per member per calendar year. Please call at least 48 hours (2 days) before you need a ride. In addition to the transportation assistance that CareSource provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

Services That Require A Referral

The following services require a referral from your PCP. This means that your PCP will recommend or request these services for you before you can get them. Your PCP will either call and arrange these services for you, give you written approval to take with you when you get the referred services, or just tell you what to do. In some cases, CareSource may authorize a specialist to make referrals for you.

Diagnostic services (X-ray, lab) done outside of your PCP's office

Participating specialists may also send you for diagnostic tests. Some may require prior authorization.

Specialist services

This includes visits to participating specialists not listed in the previous section, such as a dermatologist. Participating specialists are listed in the Provider Directory.

Outpatient hospital services



Physical and occupational therapy

You can make up to 30 visits per year without a prior authorization. Members under 21 years of age may have more visits if medically necessary as part of Healthchek services. Prior authorization may be required.

Renal dialysis (kidney disease)

Services That Require A Referral And Prior Authorization

The following services require a referral from your PCP and prior authorization from CareSource before you can get them. Your PCP will ask for a prior authorization from us then schedule these services for you. If you are seeing a specialist, he/she will get approval from your PCP then your appointment or services will be scheduled.

In-patient hospital services

Emergency services do not require a referral or prior authorization. Semi-private room and board is included.

Hospice care (care for terminally ill, e.g., cancer patients)

Nursing facility services for a short-term rehabilitative stay

Some home health services

Some durable medical equipment, including hearing aids

Developmental therapy services for children aged birth to six years

Orthotics/prosthetics

Ambulance and ambulette transportation

Emergencies do not require a referral or prior authorization.

Orthodontia

Some pain management services

Services from an out-of-network provider



Prescription Drugs

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

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

Some drugs may also have quantity (amount) limits and some drugs are never covered, such as drugs for weight loss.

If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing.

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

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



ADDED CARESOURCE BENEFITS

CareSource also offers the following extra services and benefits to members. These are not available with Ohio Medicaid. They are available at no cost to you. They include:

Dental Care

Good dental care is an important part of your health. You should visit your dentist for a routine dental exam every six months. These exams help catch problems early. Then you can get proper treatment to help correct any problems before they get worse. Ohio Medicaid covers one dental exam every year. However, as a CareSource member you can receive two dental exams every year.

CareSource 24 Nurse Advice Line

CareSource has a 24-hour nurse advice line you can call any time with health or medical questions. Please see page 4 of this handbook for more details.



Care Management and Outreach Services

CareSource has nurses and other outreach workers on staff who can work with you one-on-one to help coordinate your health care needs. They can contact you by phone:

- If your doctor requests one to contact you
- If you request a phone call
- If our care management staff feels their services would be helpful to you or your family

CareSource offers care management services that are available to children and adults with special health care needs. CareSource staff is trained to help you and your family with any special medical problems like asthma, high blood pressure, or mental health conditions.

CareSource offers Care Management programs for the following conditions:

- Asthma management
- Emergency department management
- Chronic obstructive pulmonary disease / Heart failure / Coronary artery disease management
- Diabetes management
- Depression management
- High blood pressure management
- Bipolar management
- Pain management
- Controlled substance management
- Healthy pregnancy and newborn

CareSource staff may ask you questions to learn more information about your health. And our staff will give you information to help you understand how to care for yourself and access services, including local resources. Our staff will talk to your PCP and other service providers to make sure you are receiving coordinated care. You may also have other medical conditions that our case managers can help you with. If you need help to stop smoking, a case manager can assist you.

Our staff can also work with you if you need help figuring out when to get medical care from your PCP, an urgent care center or the emergency room.

Please call us if you have any questions regarding care management services. We are happy to assist you. To contact a CareSource case manager, call **1-877-892-7479** (TTY: 1-800-750-0750 or 711).

Disease Management

CareSource offers disease management programs. They can help you learn about your health and how you can better manage your specific health conditions. These programs are available to you at no cost. We have programs for:

- Asthma
- Diabetes

Goals of our programs include:

- Helping you understand how to take good care of yourself
- Helping you adopt a healthy lifestyle
- Working with your doctor to reach your health goals

Babies First Program

If you are pregnant, you can earn up to \$150 in gift cards to local stores by getting prenatal care for you and preventive care for your baby. Call our Member Services Department to get your Babies First coupons. Just follow the instructions on each coupon and mail them to the address indicated. You will receive gift cards for complete and verified coupons. Our Babies First brochures and coupons explain all coupon guidelines including redemption time limits.

Transportation

If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. Please call **1-800-488-0134** to arrange a ride at least 48 hours (two business days) before your appointment.

CareSource also offers additional transportation services, if needed. We cover up to 30 one-way trips per member per calendar year to health care, WIC and redetermination appointments. To arrange a ride, call CareSource at **1-800-488-0134**. Choose the menu option for members, then the option for transportation.

If you participate in our care management program, your transportation benefit may be extended to support a care management plan of care and coordination. To contact a CareSource case manager, call **1-877-892-7479** (TTY: 1-800-750-0750 or 711).

Please call as soon as you know you need a ride. Please call at least 48 hours (two business days) ahead of your doctor's visit. Rides are available at no cost to you. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room.

CareSource Transportation Policy

Please review the following information carefully to understand your responsibilities. These rules have been made to help ensure your safety and to avoid transportation delays.

Member Transportation Responsibilities

1. Members are expected to:
 - Call to arrange transportation 48 hours (two business days) in advance. *Saturday, Sunday, and holidays do not count.*
 - Have the complete address of the health care provider's office that you are going to.
 - Be at your pick-up address at least one hour before your appointment time. This will ensure that the driver has adequate travel time so you are not late for your appointment.
 - Show your ID card to the driver before using transportation services.
 - Be ready when the driver gets there. The driver can wait for only five minutes. *After five minutes, he/she will leave and this will count against you as a "no-show".*
 - If you can't make it, please call to cancel transportation at least one hour before your scheduled pick-up time.

- Ask the provider's office to call the transportation company for your return trip home. If you need to have a prescription filled at the provider's facility before leaving, please do so before requesting the return-trip call.
2. Members who are not ready and waiting cause no-show transportation charges for attempting to pick you up for your appointment. The transportation company reserves the right to take away your transportation benefit for six months after three no-shows within three months. A no-show is defined as:
 - Not being at the pick-up address at least one hour before your appointment time.
 - The driver waits five minutes and leaves.
 - Not calling to cancel at least one hour before the scheduled pick-up time.
 3. Members are expected to be courteous and show respect to the transportation company and CareSource staff. Improper, discourteous behavior may result in a six-month suspension of transportation benefits for the family. Improper behavior includes:
 - Use of profanity (swearing), name-calling, or verbal abuse.
 - Threats of physical abuse to the transportation company, drivers, or CareSource staff.

CareSource and the transportation company reserve the right to immediately discontinue transportation services to members who violate these guidelines or misuse or abuse the transportation benefit.

Please keep this policy in mind. We want your transportation experiences to be positive. Please call Member Services at **1-800-488-0134** (TTY 1-800-750-0750 or 711) if you have any questions or concerns.

In addition to the transportation assistance that CareSource provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.



Eyeglasses

You can choose from a large selection of certain stylish eyeglass frames, including wire-rim frames. These frames are available, in addition to those approved by Ohio Medicaid, at no cost to you. Ask your vision care provider to show you which frames are available to you.

Health Information

Preventive medical and dental care is an important part of keeping you and your family healthy. Regular care helps your primary care doctor find problems early so they can be treated before they get worse.

Knowing how to lead a healthy lifestyle also helps you to stay well. CareSource offers information about well-child care, immunizations, family planning and health and safety through our many brochures and member newsletters. We give special attention to pregnant members, new mothers and members with asthma. You may receive health information:

- Through the mail.
- From our website at www.caresource.com.
- By calling us at **1-800-488-0134** to request it.

HEALTHCEK PROGRAM

Healthcek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthcek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone on Medicaid from birth to under 21 years of age. These exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at the following ages:

- Birth
- 3-5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months



- 15 months
- 18 months
- 24 months
- 30 months
- After that, children should have at least one exam per year.

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

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

- Preventive checkups for newborns, infants, children, teens, and young adults under the age of 21.
- Healthcek screenings:
 - Complete medical exams (with a review of physical and mental health development)
 - Vision exams
 - Dental exams
 - Hearing exams
 - Nutrition checks
 - Developmental exams
 - Lead testing

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

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Some services may require a referral from your PCP or prior authorization by CareSource. Also, for some EPSDT items or services, your provider may request prior authorization for CareSource to cover things that have limits or are not covered for members over age 20. Please see pages 11-12 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members from birth to under 21 years of age who have special health care needs. Please see page 14 to learn more about the care management services offered by CareSource.

Call your PCP to schedule an appointment for a Healthchek exam. CareSource asks that you schedule exams for all eligible family members regularly. You should try to schedule the first exam within 90 days of becoming a member. If you would like more information on the Healthchek program, please contact our Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). We can help you:

- Access care
- Find a provider

- Make an appointment
- Find out what services are covered and which ones may need prior authorization
- Arrange transportation, if needed

SERVICES NOT COVERED BY CARESOURCE OR OHIO MEDICAID

CareSource will not pay for services or supplies received without following the directions in this handbook.

CareSource will not pay for the following services that are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother.
- Acupuncture and biofeedback services.
- All services or supplies that are not medically necessary.
- Comfort items in the hospital (e.g. TV or phone).
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid.
- Infertility services for males or females, including reversal of voluntary sterilizations.
- Inpatient hospital custodial care.
- Inpatient treatment to stop using drugs and/or alcohol (In-patient detoxification services in a general hospital are covered).
- Paternity testing.
- Plastic or cosmetic surgery that is not medically necessary.
- Services for the treatment of obesity unless determined medically necessary.
- Services to find cause of death (autopsy).
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.



This is not a complete list of the services that are not covered by Medicaid or CareSource. If you have a question about whether a service is covered, please call the Member Services Department.

CareSource provides services to our members because of a contract that CareSource has with the Ohio Department of Job and Family Services (ODJFS). If you want to contact ODJFS, you can call or write to:

Ohio Department of Job and Family Services
Bureau of Policy and Health Plan Services
P.O. Box 182709
Columbus, OH 43218-2709
1-800-605-3040 or 1-800-324-8680
TTY: 1-800-292-3572

You can also visit ODJFS on the web at www.jfs.ohio.gov/ohp.

MEDICAID ELIGIBILITY AND OTHER HEALTH INSURANCE

Accidental Injury Or Illness (Subrogation)

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



Other Health Insurance (Coordination Of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call the Member Services Department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent, then you need to call the Member Services Department to give us the

information. It is also important to call Member Services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

Members with other insurance: CareSource follows Ohio insurance guidelines for members with commercial insurance. Your commercial insurance is considered your primary coverage. CareSource is secondary. You should follow the guidelines of your primary insurance when you get medical care. Be sure to show your providers and pharmacists both insurance ID cards at every visit.

Providers will bill your primary insurance first. After your primary insurance pays its allowable amount, CareSource will be billed. CareSource pays the difference between the actual primary payment and the amount CareSource would have paid as primary.

You should let CareSource and your county caseworker know right away if your "other" insurance changes.

Loss of Medicaid Eligibility

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this would happen, CareSource would be told to stop your membership as a Medicaid member and you would no longer be covered by CareSource. If you have questions about your eligibility, please contact your county caseworker.

Transportation can be provided for your redetermination appointment, if needed. Please see pages 14-15 in this handbook or call us at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for more details.

Loss of Insurance Notice (Certificate of Creditable Coverage)

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

Automatic Renewal of CareSource Membership

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

YOUR MEMBERSHIP RIGHTS

As a member of CareSource you have the following rights:

- To receive information about CareSource, our services, our practitioners and providers and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure that others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To ask for, and get, a copy of your medical records, and to be able to ask that the record be changed/ corrected if needed.
- To be able to say yes or no to having any information about you given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or MCP must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See pages 23-24 of this handbook for information.
- To be able to get all MCP written member information from the MCP:
 - at no cost to you;
 - in the prevalent non-English languages of members in the MCP's service area;
 - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from CareSource and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See pages 32-33 which explain about advance directives. You can also contact Member Services for more information.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on CareSource's panel at least monthly. CareSource must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that the MCP, the MCP's providers or ODJFS will not hold this against you.
- To know that the MCP must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider on CareSource's panel for covered woman's health services.



- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see you, CareSource must set up a visit with a provider not on our panel.
- To get information about CareSource from us.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
 United States Department of Health and Human Services
 233 N. Michigan Ave. – Suite 240
 Chicago, Illinois 60601
 (312) 886-2359 (312) 353-5693 TTY

Bureau of Civil Rights
 Ohio Department of Job and Family Services
 30 E. Broad St., 30th Floor
 Columbus, Ohio 43215
 (614) 644-2703 1-866-227-6353 1-866-221-6700 TTY
 fax: (614) 752-6381

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

Privacy Practices

This notice describes how medical information about you may be used and disclosed by CareSource and how you can get access to this information. Please review it carefully.

CareSource respects your right to privacy. This notice explains how, when and why we use or share the protected health information (PHI) we keep about you.

Your PHI includes information used to identify you and to document your health, your medical treatment, or

payment for health care you receive.

This notice also explains your rights with respect to your PHI.

The CareSource Privacy Officer can be reached by mail at:

CareSource
 Attn: Privacy Officer
 P.O. Box 8738
 Dayton, OH 45401-8738

Or by telephone at **1-800-488-0134**, ext. 2023 (TTY: 1-800-750-0750 or 711). Please use this address or phone number for any issue in this notice that asks you to contact the CareSource Privacy Officer.

How and When We Use or Share Your PHI

CareSource is required by law to keep your PHI private. We must also give you this notice of our legal duties and how we keep your information private. Below are the ways the law allows or requires us to use or share your PHI without getting your permission.

To pay claims - We may use or share your PHI in order to pay for health services you receive. For example, we may use information about your treatment or condition to make sure the services you get are covered by CareSource. We may also give your PHI to another health plan that may need it to process and pay claims for you.

To operate our business - We may use or share your PHI to administer our health plan. For example, we may use it to review and improve the quality of health care you receive, to contact you to remind you about an appointment, to tell you about a different type of treatment, or to send you health-related materials.

Sometimes we give your PHI to outside organizations so they can assist us with our operations. They include lawyers, accountants, consultants and others. We require them to keep your PHI private, too.

So you can get treatment - We may share your PHI with a friend, a family member or others when you need care



and are unable to make health care decisions for yourself at the time. For example, if you are unconscious or if there is an emergency, we may find it in your best interest to share your PHI with a relative or friend so they can help you get the care you need. If you are able to make health care decisions for yourself, we will not share your PHI with others unless you ask us to.

Other uses and disclosures – We may share your PHI:

- For any purpose required by law
- For public health activities such as required reports of diseases, injuries, births or deaths
- If we think you or a child is involved in or a victim of abuse, neglect or domestic violence
- If a government agency is doing an investigation
- If a court orders us to (In most cases, you will be notified of this)
- To report crimes or injuries to law enforcement agencies
- To a coroner or medical examiner so that a deceased body can be identified or to learn the cause of death
- To arrange an organ or tissue donation or transplant for you
- For research approved by an institutional review board that has rules to ensure privacy
- If you are a member of the military or for national security activities
- To obey workers' compensation laws
- If we believe, in good faith, that it is necessary in order to save someone else's health or life

We will not use or share your PHI for any other purpose unless you sign a form that permits us to. If you sign a form then change your mind, you can take back your permission for future uses by writing to the CareSource Privacy Officer.

Special Rules for Disclosure of Your Mental Health, Substance Abuse, HIV/AIDS, and Long-term Care Information - Ohio law requires that we obtain your authorization in many instances before disclosing the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition; before disclosing information about drug and alcohol treatment you may have received

in a drug and alcohol treatment program; before disclosing information about mental health services you may have received; and before disclosing certain information to Ohio's long-term care investigators. For full information on when such authorization may be necessary, you can contact the CareSource Privacy Officer.

Your Rights

You have the right to:

- Look at or get copies of your PHI that we have. Requests are normally fulfilled within 30 days.
- Receive a list of times we have disclosed (shared) your PHI for the past six (6) years before your request.
- Ask us to change or correct your PHI. Your request must include your reason for it. We will carefully consider all change requests. However, we are not required to make them. If we do make a change, we may also notify others who work with us and who have copies of the uncorrected records if we think they need to know.
- Ask us to limit how we use or share your PHI for certain purposes. We will carefully consider all requests. However, we are not required to make them. If we agree to a limit, both you and CareSource have the right to cancel the agreement. If CareSource cancels the agreement, we will notify you.
- Ask us to send communications regarding your PHI to you in another way or to another place. For example, if you don't want messages left on your answering machine or if you want information mailed to a different address, you can request it. We will accommodate requests that clearly provide information that the disclosure of all or part of the information could endanger you.

Please make the above requests in writing. They must be signed by you or your representative. If you would rather use one of our printed forms to make your request, you can ask for forms from the CareSource Privacy Officer.



Please send all requests to the CareSource Privacy Officer.

You also have the right to:

- Get a paper copy of this notice.
- File a written complaint with the CareSource Privacy Officer if you feel your privacy rights have been violated. You can also file a written complaint with the Secretary of the U.S. Department of Health and Human Services within 180 days of when you think your rights were violated. You will not be penalized for filing a complaint.

This original notice was effective April 14, 2003. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice and the new one would apply to all PHI we keep. If this happens, we will mail you a copy of the new notice. You can also ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

MEMBER RESPONSIBILITIES

As a member of CareSource you must also be sure to:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your ID card and present it before receiving services.
- Never let anyone else use your ID card.
- Notify your county caseworker and CareSource of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and your county caseworker know if any member of your family has other health insurance coverage.
- Provide the information that CareSource and your health care providers need in order to provide care for you.
- Understand as much as possible about your health

issues and take part in reaching goals that you and your health care provider agree upon.

Consult our website (www.caresource.com) or newsletters annually for any updates to member rights and responsibilities.

FRAUD, WASTE AND ABUSE

CareSource has a program designed to handle cases of managed care fraud. Fraud can be committed by providers or members. We monitor and take action on any member or provider fraud, waste and abuse. Some examples are:

Provider fraud, waste and abuse:

- Prescribing drugs, equipment or services that are not medically necessary
- Scheduling more frequent return visits than are medically necessary
- Billing for services not provided to you
- Billing for more expensive services than provided

Member fraud, waste and abuse:

- Sharing your CareSource ID card with another person
- Forging a doctor's signature on Babies First coupons, prescriptions, etc.
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

IF YOU SUSPECT FRAUD, WASTE OR ABUSE

If you think a doctor or a CareSource member is committing fraud, waste or abuse you can report your concerns to us by:

- Calling us at **1-800-488-0134** and selecting the menu option for reporting fraud
- Sending an e-mail to fraud@caresource.com
- Faxing us at 1-800-418-0248
- Visiting our website at www.caresource.com and completing the Fraud, Waste and Abuse Reporting Form and mailing it to the address shown

- Sending us a letter addressed to:

CareSource
Attn: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45402

When you report fraud, waste or abuse, please give us as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your report will be kept confidential to the extent permitted by law.

HOW TO LET CARESOURCE KNOW IF YOU ARE UNHAPPY OR DO NOT AGREE WITH A DECISION WE MADE

We hope you will be happy with CareSource and the service we provide. If you are unhappy with anything about CareSource or its providers, you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know this. CareSource wants you to contact us so that we can help you. To contact us, you can:

- Call the Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711), or
- Fill out the form in your member handbook (page 27), or
- Call the Member Services Department to request they mail you a form, or
- Visit our website at **www.caresource.com**, or
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your CareSource member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

CareSource
Grievance Department
PO Box 1947
Dayton, OH 45401-1947

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

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

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

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

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

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

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



If you are not happy with our answer to your grievance, you can ask us to reconsider it. To do so, you must call or send a letter to CareSource within 15 working days of getting our answer/decision about your grievance. A meeting will be held within 10 working days from the date CareSource gets your request. You, and/or someone you have chosen to represent you, can be at the meeting and present information. CareSource will send you an answer by certified mail within three working days of the meeting.

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

Ohio Department of Job and Family Services
Bureau of Policy and Health Plan Services
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-605-3040 or 1-800-324-8680
(TTY: 1-800-292-3572)

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

State Hearings

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

- A decision is made to deny services
- A decision is made to reduce, suspend, or stop services before all of the approved services are received
- A provider is billing you because CareSource has denied payment of the service
- A decision is made to propose enrollment or continue enrollment in the Pharmacy Controlled Substance Program (CSP)
- A decision is made to deny your request to change your Pharmacy Controlled Substance Program (CSP) provider

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

to reduce, suspend, or stop services before all of the approved services are received and you request the hearing within 15 calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first. You may have to pay for services you received after the proposed date to reduce, suspend, or stop services if the hearing officer agrees with our decision.

To request a hearing you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at **1-866-635-3748**, or submit your request via e-mail at **bsh@jfs.ohio.gov**. A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from CareSource and a hearing officer from ODJFS. CareSource will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules. If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at **1-800-589-5888** for the local number.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the MCP or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

External Review

In addition to a state hearing, you may ask for an independent review if CareSource decides not to approve medical care that has been requested for you. This is done by a certified medical review company. It is not done by CareSource. You must go through CareSource's appeal process first and ask for one within 45 days of getting our answer to your appeal.

To ask for one, please write to us at:

CareSource
ATTN: Independent Review – QI Dept.
P.O. Box 8738
Dayton, OH 45401-8738

Or you can call Member Services to request it. Just call **1-800-488-0134**. Your case may be urgent. If so, you will get an answer within 72 hours of asking for the review. If it is not urgent, you will get an answer in 30 days.



MEMBER GRIEVANCE/APPEAL FORM

OHIO

Member Name _____ Member Address _____ _____	Member ID # _____ Member Telephone _____
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If the grievance/appeal concerns a provider(s), please supply the following information, if known:

Name of Provider(s) _____

Address _____

Telephone _____

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

_____ (Member Signature) _____ (Date Filed)

<p>OFFICE USE ONLY</p> <p>Date Received: _____</p> <p>Received By: _____</p> <p>Grievance Level 1 2</p> <p>Hearing Date: _____</p>	<p>Action taken to resolve grievance/appeal:</p> <p>_____ (Signature Plan Rep) _____ (Resolution Date)</p>
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MEMBERSHIP TERMINATIONS – GETTING OUT OF CARESOURCE

We hope you will be happy with CareSource and discuss with us any problems or concerns you may have so we can try to resolve them.

Ending Your MCP Membership

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



If you want to end your membership during the first three months of your membership or open enrollment month for your area you can call the Managed Care Enrollment Center (MCEC) at **1-800-605-3040** (TTY: 1-800-292-3572). You can also submit a request on-line to the MCEC website at **www.ohiomcec.com**. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

Choosing A New Plan

If you are thinking about ending your membership to change to another health plan, you should learn about your choices, especially if you want to keep your current doctor(s). Remember, each health plan has its own list of doctors and hospitals that they will allow you to use. Each health plan also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a health plan you are thinking of

joining, or if you simply would like to ask questions about the health plan, you may either call the plan or call the MCEC at **1-800-605-3040** (TTY: 1-800-292-3572). You can also find information about the health plans in your area by visiting the MCEC website at **www.ohiomcec.com**.

Just Cause Membership Terminations

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

1. You move and your current MCP is not available where you now live and you must receive non-emergency medical care in your new area before your MCP membership ends.
2. The MCP does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and all of the services aren't available on your MCP's panel.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCP's panel.
5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your MCP's panel and he/she was the only PCP on your MCP's panel that spoke your language and was located within a reasonable distance from you. Another health plan has a PCP on their panel that speaks your language that is located within a reasonable distance from you and will accept you as a patient.



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

You may ask to end your membership for Just Cause by calling the MCEC at **1-800-605-3040** (TTY: 1-800-292-3572). ODJFS will review your request to end your membership for Just Cause and decide if you meet a Just Cause reason. You will receive a letter in the mail to tell you if ODJFS will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless ODJFS tells you differently. If your Just Cause request is denied, ODJFS will send you information that explains your state hearing right for appealing the decision.

Things To Keep In Mind If You End Your Membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use CareSource doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan's Member Services Department. If they are unable to help you, call the MCEC at **1-800-605-3040** (TTY: 1-800-292-3572).
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or X-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

Optional Membership Terminations

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

- Eligible for Supplemental Security Income (SSI) under Title XVI;
- Receiving foster care or adoption assistance under Title IV-E;
- In foster care or other out-of-home placement; or
- Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh).

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

If you believe that you/your child meet any of the above criteria and do not want to be a member of a managed care plan, you can call the Ohio Department of Job and Family Services (ODJFS) Managed Care Enrollment Center at **1-800-605-3040** (TTY: 1-800-292-3572). If someone meets the above criteria and does not want to be an MCP member, their membership will be ended.

Can CareSource End My Membership?

CareSource may ask the Ohio Department of Job and Family Services (ODJFS) to end your membership for certain reasons. The ODJFS must okay the request before your membership can be ended. The reasons that CareSource can ask to end your membership are:

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

QUALITY HEALTH CARE

We want to make sure that you receive quality health care. We do this by:

- Reviewing the care you receive from your doctors and other health care providers.
- Finding and correcting any problems related to proper medical care.
- Making sure care is available to you when you need it.
- Providing health education information to you and your providers.



Review of Health Care Services

CareSource keeps track of the services you get from health care providers. We discuss some services with your providers before you get them to make sure they are appropriate and necessary. For example, we review surgeries or stays at a hospital (unless they are emergencies). This is called utilization management. It makes sure you get the right amount of care you need when you need it.

All utilization management determinations are made by qualified Physician Reviewers. CareSource monitors the work of our reviewers on an ongoing basis. Part of the monitoring includes testing reviewers by presenting each of them with the same cases to ensure they make consistent and objective determinations.

CareSource determines if a service can be covered or not within 14 calendar days. This can be done quicker if the member's medical condition warrants it. We notify your doctor in writing of the determination and the reason for it. If we are not able to cover the service, we notify you in writing, too. The letter includes our phone number in case you want to call us for more information. If you are not happy with the determination, you can appeal it by calling or writing to CareSource. Your case will be re-reviewed by a different doctor from an appropriate specialty area, and you will be notified of the determination in writing.

You can contact us at any time about utilization management or prior authorization requests. Just call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). You can also send us an e-mail at any time through our website. Just visit **www.caresource.com**.

Any decisions we make with your providers about the medical necessity of your health care are based only on how appropriate the care setting or services are. CareSource does not reward providers or our own staff for denying coverage or services. We do not offer financial incentives to our staff that encourage them to make decisions that result in underutilization.

CareSource may decide that a new development not currently covered by Medicaid will be a covered benefit. This includes newly developed:

- Health care services
- Medical devices
- Therapies
- Treatment options

Coverage is based on:

- Updated Medicaid and Medicare rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

You can contact CareSource to get any other information you want. This includes information about:

- Our structure and operations
- How we pay providers
- How we work with other health plans if you have other coverage
- Results of member surveys
- How many members disenroll from CareSource
- Benefits, eligibility, claims or participating providers



If you want to tell us about things you think we should change, please call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). Our members' health is always our top priority.

USING ADVANCE DIRECTIVES TO STATE YOUR WISHES ABOUT YOUR MEDICAL CARE

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

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

You have a choice

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

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

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

This information also explains how you can state your wishes about the care you would want if you could not choose for yourself.

This information does not contain legal advice, but will help you understand your rights under the law.

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

What are my rights to choose my medical care?

You have the right to choose your own medical care. If you don't want a certain type of care, you have the right to tell your doctor you don't want it.

What if I'm too sick to decide? What if I can't make my wishes known?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want.

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

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order.

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

Do I have to fill out an advance directive before I get medical care?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

Who can fill out an advance directive?

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

Do I need a lawyer?

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

Do the people giving me medical care have to follow my wishes?

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

Living Will

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

How does a Living Will work?

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when

you are:

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

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes.

Only you can change or cancel your Living Will. You can do so at any time.

Do Not Resuscitate Order

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

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

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

Durable Power of Attorney

A Durable Power of Attorney for medical care is different from other types of powers of attorney. This information is only about a Durable Power of Attorney for medical care, not about other types of powers of attorney.

A Durable Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while.

Who should I choose?

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

When does my Durable Power of Attorney for medical care take effect?

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

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

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

Declaration For Mental Health Treatment

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

The Declaration for Mental Health Treatment supersedes a Durable Power of Attorney for mental health care, but does not supersede a Living Will.

What is the difference between a Durable Power of Attorney for medical care and a Living Will?

Your Living Will explains, in writing, the type of medical care you would want if you couldn't make your wishes known.

Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.



If I have a Durable Power of Attorney for medical care, do I need a Living Will, too?

You may want both. Each addresses different parts of your medical care.

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

A Durable Power of Attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can't act for yourself. A Durable Power of Attorney for medical care does not supersede a Living Will.

Can I change my advance directive?

Yes, you can change your advance directive whenever you want.

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

If I don't have an advance directive, who chooses my medical care when I can't?

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also.

Other matters to think about

What about stopping or not using artificially supplied food and water?

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

- If you are expected to die and can't make your wishes known, and your Living Will simply states you don't want life-support methods used to lengthen your life, then artificially supplied food and water can be stopped or not used.
- If you are expected to die and can't make your wishes known, and you don't have a Living Will,

then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.

- If you are in a coma that is not expected to end, and your Living Will states you don't want artificially supplied food and water, then artificially supplied food and water may be stopped or not used.
- If you are in a coma that is not expected to end, and you don't have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water. However, he or she must wait 12 months and get approval from a probate court.

By filling out an advance directive, am I taking part in euthanasia or assisted suicide?

No, Ohio law doesn't allow euthanasia or assisted suicide.

Where do I get advance directive forms?

Many of the people and places that give you medical care have advance directive forms. Ask the person who gave you this information for an advance directive form — either a Living Will, a Durable Power of Attorney for medical care, a DNR Order, or a Declaration for Mental Health Treatment. A lawyer could also help you.

What do I do with my forms after filling them out?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Durable Power of Attorney for medical care, give that person a copy.

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

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

Organ and Tissue Donation

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

lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

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

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card, or
2. You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

This information is endorsed by the following organizations:

*Association of Ohio Philanthropic
Homes and Housing for the Aging*

Office of the Attorney General, State of Ohio

Ohio Academy of Nursing Homes

Ohio Council for Home Care

Ohio Department of Aging

Ohio Department of Health

Ohio Department of Job and Family Services

Ohio Department of Mental Health

Ohio Health Care Association

Ohio Hospice Organization

Ohio Hospital Association

Ohio State Bar Association

Ohio State Medical Association

Office of Communications

JFS 08095 (Rev. 10/2009)

Equal Opportunity Employer

WORD MEANINGS

Advance Directives or Living Will — Documents you sign in case you become seriously ill to let your doctor and others know your wishes concerning medical treatment. You sign them while you are still healthy and able to make such decisions.

Benefits — Health care services that are covered by CareSource.

Grievance — A complaint about CareSource or its health care providers.

Member — An eligible Medicaid recipient who has joined CareSource and receives health care services from participating providers.

Non-Participating Provider — A doctor, hospital, pharmacy or other licensed health care professional who has not signed a contract agreeing to provide services to CareSource members. Please see “When You Can See A Non-Participating Provider” on page 6 of this handbook.

Participating Provider — A doctor, hospital, pharmacy or other licensed health care professional who has signed a contract agreeing to provide services to CareSource members. They are listed in our Provider Directory.

Primary Care Provider (PCP) — A participating provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Prior Authorization — Sometimes participating providers contact CareSource about the care they want you to get. This is done before you get the care to make sure it is the best care for your needs and that it will be covered. It is needed for some services that are not routine, such as home health care or some scheduled surgeries.

Provider Directory — A list of the doctors and other health care providers you can go to as a CareSource member.

Referral — A request from a PCP for his or her patient to see a specialist, such as a surgeon, for care.

Specialist — A doctor who focuses on a particular kind of health care such as a surgeon or a cardiologist (heart doctor).





ACCREDITED
HEALTH PLAN (for Medicaid)
HEALTH CALL CENTER

OH-MCFC-01e

ODJFS Approved: 8/25/2011



www.caresource.com

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