



Section 5 – Member Support Services and Benefits

CareSource provides a wide variety of support and educational services and benefits to our members to facilitate their use and understanding of our plan's services, to promote preventive health care, and to encourage appropriate use of available services. Many of these extra benefits are not available through traditional Fee-For-Service Medicaid. Remember, we are always happy to work in partnership with you to meet the health care needs of our members.

New Member Kits – Medicaid/Children's Buy-In

Each new member household receives a new member kit upon enrollment in CareSource.

This kit contains:

- A membership ID card for each person in the family who has joined the health plan
- A current provider directory that lists health care providers and facilities participating with CareSource (Medicaid only)
- A member handbook which explains plan services and benefits and how to access them
- A health assessment survey (Medicaid only)
- CareSource's Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPAA)
- Other preventive health education materials and information

New Member Kits – Medicare

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

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

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

- Initial acknowledgement letter
- CMS confirmation letter
- Identification card

Member Services – Medicaid/Children's Buy-In

CareSource provides assistance to members with questions or concerns about services or benefits. Representatives are available to ABD Medicaid and CFC Medicaid members by telephone Monday through Friday, 7 a.m. to 7 p.m., except on holidays.

- **Aged, Blind or Disabled (ABD) Medicaid** members access Member Services by calling our toll-free number, **1-800-993-0780** (TTY for the hearing impaired: 1-800-750-0750 or 711) and following the menu prompts. Members are encouraged to call for assistance.
- **Covered Families and Children (CFC) Medicaid** members access Member Services by calling our toll-free number, **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711) and following the menu prompts. Members are encouraged to call for assistance.
- **Children's Buy-In** members access Member Services by calling our toll-free number, **1-866-415-0584** (TTY for the hearing impaired: 1-800-750-0750 or 711) and following the menu prompts. Members are encouraged to call for assistance.



Member Services — Medicare

CareSource Advantage assists Special Needs Plan (SNP) members with questions or concerns about services, benefits, and enrollment by telephone Monday through Friday, 8 a.m. to 8 p.m. Members access Member Services by calling our toll-free phone number, **1-800-708-8729** (TTY for the hearing impaired: 1-800-750-0750 or 711).

CareSource 24

Members can call our URAC accredited nurse triage line 24 hours a day, seven days a week. With CareSource 24, members have unlimited access to talk with a caring and experienced staff of Registered Nurses about symptoms or health questions. Nurses assess members' symptoms using physician-developed guidelines determine the urgency of the complaint and direct members to the most appropriate place for treatment. CareSource 24 nurses educate members about the benefits of preventive care and make referrals to our care management programs. The nurses promote the relationship with the primary care provider by explaining the importance and the role of the primary care provider in coordinating the member's care.

Key features of this service include nurses who:

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

Medicaid and Children's Buy-In members access CareSource 24 by calling our dedicated toll-free phone number, **1-866-206-0554** (TTY for the hearing impaired: 1-800-750-0750 or 711).

Medicare members access CareSource 24 by calling our dedicated toll-free phone number, **1-866-206-0569** (TTY for the hearing impaired: 1-800-750-0750 or 711).

Care Management/Outreach

CareSource provides the services of care management nurses and outreach specialists to provide one-on-one, personal interaction with patients. Please feel free to refer patients who might need individual attention to help them manage special health care problems. Care management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for encouraging non-compliant patients, reinforcing medical instructions, and assessing social needs as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, and postpartum and infant care. We also offer individualized education and support for many diseases including asthma. If you would like to refer a member for care management services, please call and follow the menu prompts to speak to someone in the Care Management Department.

Care Management Services — CareSource's Care Management program is a fully integrated health management program that strives for member understanding of and satisfaction with their medical care. More importantly, it's designed to support the care and treatment you provide to your patient. We stress the importance of keeping appointments and provide transportation to the providers' office. Through one-on-one, personal interaction with outreach specialists and nurse case managers, we help your patient via assessment, coordination of care, education and support. In addition, we help connect your patient with additional community resources.

CareSource encourages you to take an active role in your patient's care management program. We will provide you with frequent care plan updates that are based on our in-depth assessments. We request your feedback and participation in the continued development of these care plans to ensure the best care for these patients.



We offer individualized education and support for many diseases, including:

- Diabetes
- Asthma
- Congestive Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease
- Hypertension
- Members with Special Health Care Needs

We also educate pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. If you know of a CareSource member that would benefit from care management, please call **1-800-488-0134**.

Emergency Department Diversion Program — CareSource is committed to making sure our members access the most appropriate health care services for their needs. Members are informed to call 911 or go to the nearest emergency room (ER) if they feel they have an emergency. CareSource covers all emergency services for our members.

We instruct members to call their primary care provider (PCP) or the CareSource 24 nurse triage service if they are unsure if they need to go to an ER. CareSource also educates members on the appropriate use of urgent care facilities and which urgent care sites they can access. We also offer enhanced reimbursement to PCP offices for holding evening or weekend hours to help ensure that our members have alternatives other than the ER available to them when they need medical care outside of normal business hours.

Member ER utilization is tracked closely. If there is frequent ER utilization, members are referred to our Care Management and Outreach Department for analysis or intervention. Members are contacted via phone or mail. Intervention includes education as well as assistance in removing any identified health care access barriers. We appreciate your cooperation in educating your patients on the appropriate utilization of emergency services.

Perinatal Care Management — CareSource has a program for perinatal and neonatal care management utilizing a staff of specialized nurses. Nurses are available to help manage high-risk pregnancies and premature births by working in conjunction with providers and members. The expertise offered by the staff includes a focus on patient education and support and involves direct telephone contact with members and providers. We encourage our prenatal care providers to notify our Care Management Department when a member with a high-risk pregnancy has been identified.

Babies First Program — CFC Medicaid

Pregnant members and new mothers can earn up to \$150 in gift cards to local stores by receiving recommended prenatal care for themselves and preventive well-child care for their children through age 15 months. Members can obtain Babies First brochures and coupons from CareSource. Each coupon contains instructions, for example, about keeping all scheduled prenatal appointments during a given trimester. Once the instructions on the coupon have been completed, members then mail the coupons to us to receive gift cards for complete and verified coupons. If you provide OB or preventive services, CareSource members may ask you to validate coupons by completing information on the back of the coupon and signing where indicated.



Eyeglass Frames — Medicaid Only

Members of our health plan can choose from a large selection of eyeglass frames, in addition to those approved by Medicaid, at no cost to them. These frames must be ordered through one of CareSource's optical labs. Please refer to our Website at www.caresource.com for additional information about vision services.

Interpreter Services — Medicaid/Medicare/Children's Buy-In (*Providers Only*)

CareSource offers sign and language interpreters for members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability. These services are available at no cost to the member or health care provider. As a provider for Medicaid consumers, you are required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. To arrange services, please contact Provider Services at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). We ask that you let us know of members in need of interpreter services as well as any members that may receive interpreter services through another resource.

Interpreter Services — Medicaid/Medicare/Children's Buy-In (*Hospitals Only*)

CareSource requires hospitals, at their own expense, to offer sign and language interpreters for members who are hearing impaired, visually impaired, do not speak English, or have limited English-speaking ability. These services should be available at no cost to the member. You are also required to identify the need for interpreter services for your CareSource patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Provider Services at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711). We ask that you let us know of members in need of interpreter services as well as any members that may receive interpreter services through another resource.

Transportation — Medicaid/Children's Buy-In

Transportation can be provided for member medical appointments with participating providers, Women Infants and Children (WIC) appointments, and Medicaid redetermination appointments with the County Department of Job and Family Services. The transportation benefit is limited to 15 round-trip visits (30 one-way trips) per member per 12-month period. Transportation is provided at no cost to the member. Members receive information upon enrollment that indicates who to call for transportation and how far in advance they need to make arrangements. Members in the Northwest, Northeast, Northeast Central, East Central, and Southeast regions can reach Transportation Services by calling **1-888-288-7050**. Members in the Central, Southwest and West Central can reach Transportation Services by calling **1-866-419-8419**.

Transportation — Medicare

Transportation can be provided for a member's medical appointments with participating providers. The transportation benefit is limited to 30 round-trip visits per member per calendar year.

Transportation is provided at no cost to CareSource Advantage members. Members receive information upon enrollment that indicates who to call for transportation and how far in advance they need to make arrangements. Members in the Northwest, Northeast, Northeast Central, East Central, and Southeast regions can reach Transportation Services by calling **1-888-288-7050**. Members in the Central, Southwest and West Central can reach Transportation Services by calling **1-866-419-8419**.

Health Education

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



Member Rights and Responsibilities — Medicaid

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

- To receive 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 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, 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 managed care provider (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.
- 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).
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your 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 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., 37th Floor
Columbus, Ohio 43215
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.

Members of CareSource are also informed of the following responsibilities:

- Use only approved providers.
- Keep scheduled provider 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 health care providers.
- Always carry your ID card and do not let anyone else use your ID card.
- Always present your ID card when receiving services.
- 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 us know if you have 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.

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

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



Member Rights and Responsibilities — Medicare

CareSource Advantage members are informed of their rights and responsibilities via their member handbook (also known as the Evidence of Coverage). All members are encouraged to take an active and participatory role in their own health and the health of their family. Member rights, as stated in the member handbook, are as follows:

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

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

We must treat you with fairness and respect at all times.

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights 1-800-368-1019** (TTY: 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs.

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

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, call Member Services.

We must protect the privacy of your personal health information.

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

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



How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services.

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

As a member of our plan, you have the right to get several kinds of information from us.

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *Provider Directory*.
 - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Member Services or visit our Website at www.caresource.com.
- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of the CareSource Advantage Evidence of Coverage, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the CareSource Advantage Evidence of Coverage plus the plan's *List of Covered Drugs (Formulary)*. This together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services.

- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the CareSource Evidence of Coverage. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision.
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the CareSource Advantage Evidence of Coverage.

We must support your right to make decisions about your care. You have the right to know your treatment options and participate in decisions about your health care.

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of the CareSource Evidence of Coverage tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

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

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

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

What if your instructions are not followed?

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

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

If you have any problems or concerns about your covered services or care, Chapter 9 of the Evidence of Coverage tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9 of the Evidence of Coverage, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

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

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

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

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



Is it about something else?

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

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3 of the CareSource Advantage Evidence of Coverage.

How to get more information about your rights.

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

- You can **call Member Services**
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2 Section 3 of the CareSource Advantage Evidence of Coverage.
- You can contact **Medicare**.
 - You can visit the Medicare Website (<http://www.medicare.gov>) to read or download the publication “Your Medicare Rights & Protections.”
 - Or, you can call 1-800-MEDICARE (**1-800-633-4227**) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan.

What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the CareSource Advantage *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 of the CareSource Advantage *Evidence of Coverage* give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 of the CareSource Advantage *Evidence of Coverage* give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage besides our plan, you are required to tell us.** Please call Member Services to let us know.
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and Medicaid card whenever you get your medical care or Part D prescription drugs.



- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 of the CareSource Advantage Evidence of Coverage tells what you must pay for your medical services. Chapter 6 of the CareSource Advantage Evidence of Coverage tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services.
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 of the CareSource Advantage Evidence of Coverage tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

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

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

Member Grievance & Appeals Procedures — Medicaid/Children's Buy-In

Members are encouraged to call or write to CareSource to let us know of any complaints regarding CareSource or the health care services they receive. Members or providers, when designated as the authorized representative, may file grievance or appeals with CareSource. Detailed grievance and appeal procedures are explained in the member handbook. Members or providers can contact CareSource at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to learn more about these procedures.



Member Grievances — Any time a member informs us that they are dissatisfied with CareSource or a health care provider, this is deemed a grievance by ODJFS. CareSource investigates all grievances. If the grievance is about a provider, a CareSource Member Services representative calls the provider's office to gather information for resolution. CareSource responds to member grievances in accordance with ODJFS-mandated time frames. If a member's grievance is about not being able to get medical care, CareSource responds within 2 business days. For grievances about getting a bill for care the member received, CareSource responds within 60 calendar days. CareSource responds to all other grievances within 30 calendar days.

If members are not satisfied with our response to a grievance, they can ask us to reconsider it by sending us a letter within 15 business days. A meeting is held within 10 business days of the date CareSource receives the request. Members, or their authorized representatives, have the right to attend the meeting and present information.

Member Appeals — CareSource notifies members in writing when we make a decision to deny a request to cover a service; reduce, suspend or stop care the member is already receiving. Members have the right to appeal the actions listed in the letter if they contact CareSource within 90 calendar days. CareSource will respond to the appeal in writing within 15 calendar days of when it was received.

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

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

Independent External Review — In addition to a state hearing, CareSource members may ask for an independent external review if CareSource decides not to approve medical care, based on medical necessity that has been requested for them. These reviews are conducted by a certified medical review organization instead of CareSource. Members must exhaust CareSource's appeal process first and request the independent external review within 45 days of the date CareSource notifies them of the appeal denial.

To request an external review, members can write to us at:

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

Or requests can be made by calling Member Services toll-free at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). For urgent cases, determinations are made within 72 hours of asking for the review. If the case is not urgent, determinations are made within 30 days.



Healthchek Program — CFC Medicaid

Healthchek is the state of Ohio's name for Early Periodic Screening Diagnosis and Treatment (EPSDT) services. This is a federally-mandated program developed for children through the age of 20 who are Medicaid recipients. **All children of these ages who are CareSource members should receive Healthchek exams.** The program is designed to provide comprehensive preventive health care services at regular intervals. Healthchek stresses health education to children and their caretakers in the areas of health maintenance and early intervention and treatment of problems discovered during exams.

Healthchek Exam Components

The Healthchek exam is a general health assessment and is composed of the following required screening components:

- Comprehensive health and development history
- Comprehensive unclothed physical examination
- Developmental assessment
- Vision and eye assessment
- Nutritional assessment
- Dental assessment and referral to a dentist, as indicated. Referrals for dental exams are recommended at 1-3 years of age; they are required at 3 years and older.
- Assessment of immunization status and administration of required vaccines
- Anemia test using hematocrit or hemoglobin determinations at indicated times
- Health education
- Sickle cell test, if indicated
- Complete urinalysis, if indicated
- Test for sexually transmitted diseases, if indicated
- Tuberculin test, if indicated
- Lead screening test at indicated times
- Pelvic examination, if indicated

Healthchek Exam Frequency

The recommended schedule for Healthchek exams is as follows:

- Birth
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- Annually after age 2 through age 20

PCPs receive a list of eligible CareSource members at the beginning of each month who have chosen or been assigned to the PCP as of that date. The list also includes indicators for patients who are due for a Healthchek exam. If there is a "Y" in the Exam Due column, that member is due to receive a Healthchek exam in the following month. You can find this list on our Website at www.caresource.com.



Healthchek Form

Please document all required components of the Healthchek exam in the member's medical record. We encourage you to use a form to ensure that you capture all of the needed data. If you don't already have forms, we encourage you to copy the form included in the Forms section of this manual or obtain a copy of the Healthchek Form from our Website at www.caresource.com.

Healthchek Codes

Exams should be coded on claim forms using CPT codes 99381 through 99395, whichever is applicable, as indicated in the following chart. Correct codes are required for timely and accurate claims payment and documentation of services provided.

New Patient/Initial Exam

CPT Code	Description
99381	Infant (age under 1 year)
99382	Early childhood (age 1-4 years)
99383	Late childhood (age 5-11 years)
99384	Adolescent (age 12-17 years)
99385	Age 18-20 years

Established Patient/Periodic Exam

CPT Code	Description
99391	Infant (age under 1 year)
99392	Early childhood (age 1-4 years)
99393	Late childhood (age 5-11 years)
99394	Adolescent (age 12-17 years)
99395	Age 18-20 years

These codes should be used along with appropriate ICD-9 diagnosis codes (V20.2 or V70.x codes). When updating routine Healthchek status at the time of an acute care visit, the next-higher level E&M CPT code may be submitted if the appropriate ICD-9 code is also submitted as a secondary diagnosis.

Healthchek Exam Referrals

If the PCP is unable to provide all of the components of the Healthchek exam or if screenings indicate a need for evaluation by a specialist, a referral must be made to another participating provider within CareSource's provider network in accordance with CareSource's referral procedures. The member's medical record must indicate where the member was referred.



Blood Lead Level Testing

The Ohio Medicaid program requires that children receive a blood lead level test at one and two years of age. This is a required part of the Healthchek exam provided at these ages. Filter paper testing is an accepted method for obtaining blood lead levels and is approved by the Ohio Department of Health (ODH).

The filter paper method offers fast, quantitative results from two drops of blood obtained through a fingerstick capillary puncture. Both hemoglobin and lead can be tested using this method and CPT code 36416 for the capillary stick. It is a less invasive method of sample collection that can be performed conveniently in a physician's office. Supplies and instructions are provided by MedTox, the lab that processes the results. Supplies are provided at no charge and lab results are delivered within 24 to 48 hours of receipt. Lead levels that exceed 10 ug/dL with this sampling method are recommended for retesting by a follow-up capillary or venous puncture according to ODH guidelines. For more information, please contact MedTox Labs directly at **1-800-FOR-LEAD** (1-800-367-5323).

Vaccines for Children Program

The federal Vaccines for Children (VFC) program makes designated vaccines available at no cost to VFC participating health care providers to administer to children under the age of 19 who are eligible for Medicaid. CareSource members under the age of 19 are eligible for these vaccines. This program in Ohio is administered by ODH.

CareSource encourages providers to participate with the VFC program. Vaccines administered to children under the age of 19 must be obtained through the VFC program which supplies vaccines to program participating providers at no cost. Providers will be reimbursed to administer vaccines to enrollees under the age of 19.

CareSource will not reimburse costs for vaccines obtained outside the VFC when provided to children under age 19.

Please bill CareSource with the appropriate CPT and ICD-9 vaccination codes for the immunization(s) being administered, and the appropriate administration code. **CareSource will pay for the administration of the vaccine** only. Billing with the vaccine codes along with the administration codes will help ensure that you are reimbursed properly for administration of the correct vaccine.

For more information about the Ohio VFC program and how to enroll and obtain vaccines, please contact:

Immunization Program
Ohio Department of Health
246 N. High Street
Columbus, OH 43215
E-mail: immunize@odh.ohio.gov
1-800-282-0546 or **(614) 466-4643** (ask to speak with the VFC representative for your county)



Immunization Schedule

Immunizations are an important part of preventive care for children and should be administered during Healthchek exams, as needed. CareSource endorses the same recommended childhood immunization schedule that is approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The recommended schedule is included in this section of the manual. This schedule is updated annually and the most current updates can be found on the Internet at www.aap.org.

Immunization Codes

Please bill CareSource with the following CPT vaccination codes, along with the appropriate ICD-9 vaccination codes, to receive reimbursement for administration of the vaccine.

Immunization	CPT Codes	ICD-9-CM Codes
DtaP	90698, 90700, 90701, 90720, 90721, 90723	99.39
Diphtheria and tetanus	90702	
Diphtheria	90719	V02.4*, 032*, 99.36
Tetanus	90703	037*, 99.38
Pertussis		033*, 99.37
IPV	90698, 90713, 90723	V12.02*, 045*, 99.41
MMR	90707, 90710	99.48
Measles	90705, 90708	055*, 99.45
Mumps	90704, 90709	072*, 99.46
Rubella	90706, 90708, 90709	056*, 99.47
HiB	90645, 90646, 90647, 90648, 90698, 90720, 90721, 90748	041.5*, 038.41*, 320.0*, 482.2*
Hepatitis B**	90723, 90740, 90744, 90747, 90748	V02.61*, 070.2*, 070.3*
VZV	90710, 90716	052*, 053*
Pneumococcal conjugate	90669	

* Indicates evidence of disease. A member who has evidence of disease during the numerator event time is compliant for the antigen.

** The two-dose hepatitis B antigen Recombivax is recommended for children between 11 and 14 years of age only.

Statewide Web-based Immunization Registry

CareSource encourages all participating health care providers to take advantage of the statewide Web-based immunization registry called IMPACT SIIS. The registry consolidates immunizations from multiple providers into one central record and provides reliable immunization history that is electronically accessible from multiple health care practice sites. It also facilitates the introduction of new vaccine protocols and sends immunization reminder/recall notices automatically. The system is designed to save time and money, reduce paperwork, and provide quick and efficient tracking of immunizations. It also streamlines inventory reporting required by the VFC program.