



CareSource® MyCare Ohio (Medicare-Medicaid Plan)

2017 Member Handbook

with Annual Notice of Change

CareSource®

Table of Contents

| | |
|---|-------------|
| A. Think about Your Medicare and Medicaid Coverage for Next Year | ii |
| B. Changes to the network providers and pharmacies | v |
| C. Changes to benefits for next year..... | v |
| Changes to benefits for medical services..... | v |
| Changes to prescription drug coverage | vi |
| D. Deciding which plan to choose..... | viii |
| If you want to stay in CareSource MyCare Ohio | viii |
| If you want to join a different MyCare Ohio plan | viii |
| If you want to change your membership in CareSource MyCare Ohio | viii |
| E. Getting help..... | x |
| Getting help from CareSource MyCare Ohio | x |
| Getting help from the Ohio Medicaid Hotline..... | x |
| Getting help from the MyCare Ohio Ombudsman..... | xi |
| Getting help from Medicare | xi |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. The call is free. For more information, visit CareSource.com/MyCare.

CareSource MyCare Ohio offered by CareSource

Annual Notice of Changes for 2017

You are currently enrolled as a member of CareSource MyCare Ohio. **Next year, there will be some changes to the plan's benefits, coverage and rules. This section tells you about the changes.**

You can end your membership in CareSource MyCare Ohio at any time.

A. Think about Your Medicare and Medicaid Coverage for Next Year

It is important to review your coverage now to make sure it will still meet your needs next year. If it does not meet your needs, you can leave the plan at any time.

If you leave our plan, you will still be in the Medicare and Medicaid programs.

- You will have a choice about how to get your Medicare benefits (go to page ix to see your choices).
- You must get your Medicaid benefits from one of the MyCare Ohio managed care plans available in your region (go to page x for additional information).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

Additional Resources

- You can get this information for free in other languages. Call 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. to 8 p.m. The call is free.
- Puede obtener esta información de forma gratuita en otros idiomas. Llame al 1-855-475-3163. La llamada es gratuita.
- You can get this Annual Notice of Changes for free in other formats, such as large print, braille, or audio. Call 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. to 8 p.m. The call is free.

About CareSource MyCare Ohio

- CareSource MyCare Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees. It is for people with both Medicare and Medicaid.
- Coverage under CareSource MyCare Ohio qualifies as minimum essential coverage (MEC). It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information on the individual shared responsibility requirement for MEC.
- CareSource MyCare Ohio is offered by CareSource. When this *Annual Notice of Changes* says “we,” “us,” or “our,” it means CareSource. When it says “the plan” or “our plan,” it means CareSource MyCare Ohio.

Disclaimers

Limitations and restrictions may apply. For more information, call CareSource MyCare Ohio Member Services. This means that you may have to pay for some services and that you need to follow certain rules to have CareSource MyCare Ohio pay for your services.

The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.

Benefits may change on January 1 of each year.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. For more information, visit CareSource.com/MyCare.

Important things to do:

- Check if there are any changes to our benefits that may affect you.** Are there any changes that affect the services you use? It is important to review benefit changes to make sure they will work for you next year. Look in sections B and C, *Changes to benefits for next year* and *Other Changes* for information about benefit changes for our plan.
- Check if there are any changes to our prescription drug coverage that may affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in section B, *Changes to benefits for next year* for information about changes to our drug coverage.
- Check to see if your providers and pharmacies will be in our network next year.** Are your doctors in our network? What about your pharmacy? What about the hospitals or other providers you use? Look in section A, *Changes to the network providers and pharmacies*, for information about our *Provider and Pharmacy Directory*.
- Think about your overall costs in the plan.** How do the total costs compare to other coverage options?
- Think about whether you are happy with our plan.**

**If you decide to stay with
CareSource MyCare Ohio:**

If you want to stay with us next year, it's easy – you don't need to do anything. If you don't make a change, you will automatically stay enrolled in our plan.

If you decide to change plans:

If you decide other coverage will better meet your needs, you can switch plans at any time. If you enroll in a new plan, your new coverage will begin on the first day of the following month. Look in section D, *Deciding which plan to choose* (page viii) to learn more about your choices.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

B. Changes to the network providers and pharmacies

Our provider and pharmacy networks have changed for 2017.

We strongly encourage you to review our current Provider and Pharmacy Directory to see if your providers or pharmacy are still in our network. An updated *Provider and Pharmacy Directory* is located on our website at CareSource.com/MyCare. You may also call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) for updated provider information or to ask us to mail you a *Provider and Pharmacy Directory*.

It is important that you know that we may also make changes to our network during the year. If your provider does leave the plan, you have certain rights and protections. For more information, see Chapter 3 of your *Member Handbook*.

C. Changes to benefits for next year

Changes to benefits for medical services

We are changing our coverage for certain medical services next year. The table below describes these changes.

| | 2016 (this year) | 2017 (next year) |
|--------------------------------------|--|--|
| Insect Repellant | Insect Repellant is not covered. | In 2017, insect repellant is a covered benefit |
| Therapy in a nursing facility | Therapy in a nursing facility did not require Prior Authorization | Therapy in a nursing facility requires prior authorization after thirty (30) visits |
| Vision | One pair of supplemental eyeglasses (lenses and/or frames) covered annually up to \$125. | One pair of supplemental eyeglasses (lenses and/or frames) covered every 2 years, up to \$125. |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. For more information, visit CareSource.com/MyCare.

Changes to prescription drug coverage

Changes to our Drug List

We sent you a copy of our 2017 *List of Covered Drugs* in this envelope. The *List of Covered Drugs* is also called the “Drug List.”

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs.

Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.

If you are affected by a change in drug coverage, we encourage you to:

- **Work with your doctor (or other prescriber) to find a different drug** that we cover. You can call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) to ask for a list of covered drugs that treat the same condition. This list can help your provider find a covered drug that might work for you.
- **Ask the plan to cover a temporary supply** of the drug. In some situations, we will cover a **one-time**, temporary supply of the drug during the first 90 days of the calendar year. This temporary supply will be for up to 30 days. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5 of the *Member Handbook*, Section D, *Why your drug might not be covered*.) When you get a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug.

Any current formulary exceptions you may have will still be covered next year until, as long as the coverage determination has not expired.

Changes to prescription drug costs

There are no changes to the amount you pay for prescription drugs in 2017. Read below for more information about your prescription drug coverage.

We moved some of the drugs on the Drug List to a lower or higher drug tier. To see if your drugs will be in a different tier, look them up in the Drug List.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

CareSource MyCare Ohio ANNUAL NOTICE OF CHANGES FOR 2017

The table below shows your costs for drugs in each of our three (3) drug tiers.

| | 2016 (this year) | 2017 (next year) |
|--|--|---|
| Drugs in Tier 1 Part D Generic Drugs Cost for a one-month supply of a drug in Tier 1 that is filled at a network pharmacy | Your copay for a one-month (30-day) supply is \$0 per prescription. | Your copay for a one-month (30-day) supply is \$0 per prescription. |
| Drugs in Tier 2 Part D Brand Drugs Cost for a one-month supply of a drug in Tier 2 that is filled at a network pharmacy | Your copay for a one-month (30-day) supply is \$0 per prescription. | Your copay for a one-month (30-day) supply is \$0 per prescription. |
| Drugs in Tier 3 Medicaid-covered Drugs Cost for a one-month supply of a drug in Tier 3 that is filled at a network pharmacy | Your co-pay is \$0 per prescription. | Your co-pay is \$0 per prescription. |
| Drugs in Tier 4 | In 2016, this tier includes only over-the-counter (OTC) drugs covered under the Medicaid benefits. Your co-pay is \$0 per prescription. | In 2017, this tier is eliminated. Tier 4 drugs are still covered but are now part of Tier 3. |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. For more information, visit CareSource.com/MyCare.

D. Deciding which plan to choose

If you want to stay in CareSource MyCare Ohio

We hope to keep you as a member next year.

To stay in our plan you don't need to do anything. If you do not sign up for a different MyCare Ohio Plan, change to a Medicare Advantage Plan, or change to Original Medicare, your enrollment in CareSource MyCare Ohio will automatically stay the same for 2017.

If you want to join a different MyCare Ohio plan

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join another MyCare Ohio plan available in your region.

To enroll in a different MyCare Ohio plan, call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. The Hotline will let you know what other plans are available to you.

If you want to change your membership in CareSource MyCare Ohio

You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services).

How you will get Medicare services

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan. 1. **You can change to:**

A Medicare health plan (such as a Medicare Advantage Plan)

Here is what to do:

Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

If you need help or more information:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

You will automatically stop getting Medicare services through CareSource MyCare Ohio when your new plan's coverage begins.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

| | |
|--|--|
| <p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p> | <p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare Services through CareSource MyCare Ohio when your Original Medicare and prescription drug plan coverage begins.</p> |
| <p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>NOTE: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call your Ohio Senior Health Insurance Information at 1-800-686-1578.</p> | <p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your Original Medicare coverage begins.</p> |

How you will get Medicaid services

You must get your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you don't want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from CareSource MyCare Ohio or another MyCare Ohio managed care plan.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care.

Once you stop getting Medicare services through our plan, you will get a new member ID Card and a new *Member Handbook* for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

E. Getting help

Getting help from CareSource MyCare Ohio

Questions? We're here to help. Please call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711). We are available for phone calls Monday – Friday, 8 a.m. to 8 p.m.

Read your 2017 Member Handbook

The *2017 Member Handbook* is the legal, detailed description of your plan benefits. It has details about next year's benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs.

An up-to-date copy of the *2017 Member Handbook* is always available on our website at CareSource.com/MyCare. You may also call Member Services at 1-855-475-3163 to ask us to mail you a *2017 Member Handbook*.

Visit our website

You can also visit our website at CareSource.com/MyCare. As a reminder, our website has the most up-to-date information about our provider and pharmacy network (*Provider and Pharmacy Directory*) and our Drug List (*List of Covered Drugs*).

Getting help from the Ohio Medicaid Hotline

The Ohio Medicaid hotline can help you find a Medicaid health care provider, explain Medicaid covered services, obtain Medicaid brochures and publications, and understand Medicaid benefits.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday - Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit CareSource.com/MyCare.

You can call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 7-1-1.

Getting help from the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman can help you if you are having a problem with CareSource MyCare Ohio. The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan. The MyCare Ohio Ombudsman helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan. The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports.

The phone number for the MyCare Ohio Ombudsman is 1-800-282-1206. TTY users should call 1-800-750-0750. The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 a.m. to 5:00 p.m. The services are free.

Getting help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227).

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.

Visit the Medicare Website

You can visit the Medicare website (<http://www.medicare.gov>). If you choose to disenroll from your Medicare-Medicaid Plan and enroll in a Medicare Advantage plan, the Medicare website has information about costs, coverage, and quality ratings to help you compare Medicare Advantage plans. You can find information about Medicare Advantage plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to <http://www.medicare.gov> and click on “Find health & drug plans.”)

Read *Medicare & You 2017*

You can read *Medicare & You 2017* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (<http://www.medicare.gov>) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



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Table of Contents

| | | |
|------------|--|-----|
| Chapter 1 | Getting started as a member..... | 3 |
| Chapter 2 | Important phone numbers and resources..... | 13 |
| Chapter 3 | Using the plan's coverage for your health care and other covered services..... | 23 |
| Chapter 4 | Benefits chart..... | 42 |
| Chapter 5 | Getting your outpatient prescription drugs through the plan..... | 85 |
| Chapter 6 | What you pay for your Medicare and Medicaid prescription drugs..... | 102 |
| Chapter 7 | Asking us to pay a bill you have gotten for covered services or drugs..... | 108 |
| Chapter 8 | Your rights and responsibilities..... | 112 |
| Chapter 9 | What to do if you have a problem or complaint (coverage decisions, appeals, complaints)..... | 134 |
| Chapter 10 | Changing or ending your membership in our MyCare Ohio Plan..... | 194 |
| Chapter 11 | Definitions of important words..... | 201 |
| | Multi-Language information..... | 206 |
| | Nondiscrimination statement..... | 207 |

If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8a.m. – 8p.m. If you need to speak to your care manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.



CareSource® MyCare Ohio (Medicare-Medicaid Plan) Member Handbook

January 1, 2017 – December 31, 2017

Your Health and Drug Coverage under CareSource MyCare Ohio (Medicare-Medicaid Plan)

This handbook tells you about your coverage under CareSource MyCare Ohio through December 31, 2017. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. **This is an important legal document.**

Please keep it in a safe place.

This plan, CareSource MyCare Ohio, is offered by CareSource. When this *Member Handbook* says “we,” “us,” or “our,” it means CareSource. When it says “the plan” or “our plan,” it means CareSource MyCare Ohio.

You can get this handbook for free in other languages. Call our Member Services Department at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. The call is free.

Puede obtener esta información de forma gratuita en otros idiomas. Llame al 1-855-475-3163. La llamada es gratuita.

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If you have any problems reading or understanding this handbook or any other CareSource MyCare Ohio information, please contact Member Services. We can explain the information or provide the information 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.



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Disclaimers

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Limitations and restrictions may apply. For more information, call CareSource MyCare Ohio Member Services or read the CareSource MyCare Ohio Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have CareSource MyCare Ohio pay for your services.



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Chapter 1: Getting started as a member

Table of Contents

| | |
|--|-----------|
| A. Welcome to CareSource MyCare Ohio..... | 4 |
| B. What are Medicare and Medicaid?..... | 4 |
| Medicare | 4 |
| Medicaid..... | 4 |
| C. What are the advantages of this plan?..... | 5 |
| D. What is CareSource MyCare Ohio's service area? | 6 |
| E. What makes you eligible to be a plan member? | 7 |
| F. What to expect when you first join a health plan | 8 |
| G. What is a care plan?..... | 8 |
| H. Does CareSource MyCare Ohio have a monthly plan premium? | 8 |
| I. About the Member Handbook | 9 |
| J. What other information will you get from us?..... | 9 |
| Your CareSource MyCare Ohio Member ID Card..... | 9 |
| New Member Letter..... | 10 |
| Provider and Pharmacy Directory | 10 |
| List of Covered Drugs..... | 11 |
| Member Handbook Supplement or “Waiver Handbook” | 11 |
| The Explanation of Benefits | 11 |
| K. How can you keep your membership record up to date? | 12 |
| Do we keep your personal health information private? | 12 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. Welcome to CareSource MyCare Ohio

CareSource MyCare Ohio, offered by CareSource, is a Medicare-Medicaid Plan. A *Medicare-Medicaid plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and Care Teams to help you manage all your providers and services. They all work together to provide the care you need.

CareSource MyCare Ohio was approved by the Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

The MyCare Ohio program is a demonstration program jointly run by ODM and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

CareSource is a nonprofit organization that has been meeting the needs of health care consumers for over 27 years. We are a community-based health plan that understands diverse needs and serves more than 1.3 million members in the state of Ohio. The CareSource approach to our members is founded on strong community partnerships and a geographic focus. We believe in a face-to-face approach to care management in order to build lasting relationships that transform lives

B. What are Medicare and Medicaid?

You have both Medicare and Medicaid. CareSource MyCare Ohio will make sure these programs work together to get you the care you need.

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Ohio Medicaid must approve CareSource MyCare Ohio each year. You can get Medicare and Medicaid services through our plan as long as:

- we choose to offer the plan, and
- Medicare and Ohio Medicaid approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medicaid services would not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medicaid services from CareSource MyCare Ohio, including prescription drugs. You do not pay extra to join this health plan.

CareSource MyCare Ohio will help make your Medicare and Medicaid benefits work better together, and work better for you. Some of the advantages include:

- You will have a Care Team that you helped put together. Your Care Team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a Care Manager. This is a person who works with you, with CareSource MyCare Ohio, and with your care providers to make sure you get the care you need. He or she will be a member of your Care Team.
- You will be able to direct your own care with help from your Care Team and Care Manager.
- The Care Team and Care Manager will work with you to come up with a care plan specifically designed to meet your needs. The Care Team will be in charge of coordinating the services you need. This means, for example:
 - » Your Care Team will make sure your doctors know about all medicines you take so they can reduce any side effects.
 - » Your Care Team will make sure your test results are shared with all your doctors and other providers.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

D. What is CareSource MyCare Ohio's service area?

CareSource MyCare Ohio is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

Our service area includes the following twelve (12) counties in Ohio:

| | |
|----------|----------|
| Columbia | Medina |
| Cuyahoga | Portage |
| Geauga | Stark |
| Lake | Summit |
| Lorain | Trumbull |
| Mahoning | Wayne |

CareSource MyCare Ohio Service Area Map



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state.

E. What makes you eligible to be a plan member?

You are eligible for membership in our plan as long as:

- you live in our service area; **and**
- you have Medicare Parts A, B and D; **and**
- you have full Medicaid coverage; **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in CareSource MyCare Ohio if you:

- have other third party creditable health care coverage; **or**
- have intellectual or other developmental disabilities and get services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID); **or**
- are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

If you are one of the following populations, your membership in the MyCare Ohio Plan is voluntary. You do not have to be in MyCare Ohio to receive Medicaid healthcare benefits.

- Indians who are members of federally recognized tribes. **or**
- **Until January 1, 2017**, children under 19 years of age who:
 - In foster care or other out-of-home placement;
 - Receiving foster care or adoption assistance;
- Those receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH) or any other family-centered, community-based, coordinated care system that receives grant funds for special health care needs. If you believe that you meet any of the above criteria, please contact Member Services for assistance.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

F. What to expect when you first join a health plan

When you first join the plan, you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. You will receive a letter telling you who your Care Manager is. You will be contacted by your Care Manager, or a member of the care management team, to schedule your first assessment.

The health care assessment will be completed with you, your family, caregivers, Care Manager, and other support people as you desire. It can be done at your home or a location of your choice, including a physician's office or hospital.

If CareSource MyCare Ohio is new for you, you can keep seeing the doctors you go to now for at least 90 days after you enroll. Also, if you already had previous approval to get services, our plan will honor the approval until you get the services. This is called a "transition period." The *New Member Letter* included with your Member Handbook has more information on the transition periods. If you are on the MyCare Ohio Waiver, your Member Handbook Supplement or "Waiver Handbook" also has more information on transition periods for waiver services.

After the transition period, you will need to see doctors and other providers in the CareSource MyCare Ohio network for most services. *A network provider is a provider who works with the health plan.* See Chapter 3, Section D for more information on getting care. Member Services can help you find a network provider.

If you are currently seeing a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services right away so we can arrange the services and avoid any billing issues.

G. What is a care plan?

A *care plan* is the plan for what health services you will get and how you will get them.

After your health care needs assessment, your Care Team will meet with you to talk about what health services you need and want. Together, you and your Care Team will make a care plan.

Your Care Team will continuously work with you to update your care plan to address the health services you need and want.

H. Does CareSource MyCare Ohio have a monthly plan premium?

No.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, Section 4, page 141. You can also call Member Services at 1-855-475-3163 (TTY 1-800-750-0750 or 711) or Medicare at 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for months in which you are enrolled in CareSource MyCare Ohio between January 1, 2017 and December 31, 2017.

J. What other information will you get from us?

You will also get a CareSource MyCare Ohio Member ID Card, a *New Member Letter* with important information, information about how to access a *Provider and Pharmacy Directory* and a *List of Covered Drugs*. Members receiving home and community based waiver services will also get a supplement to their Member Handbook that gives information specific to waiver services. If you do not get these items, please call Member Services for assistance.

Your CareSource MyCare Ohio Member ID Card

Under the MyCare Ohio program, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions covered by the plan. Here is a sample card to show you what yours will look like:



If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it later.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

New Member Letter

Please make sure to read the *New Member Letter* sent with your Member Handbook as it is a quick reference for some important information. For example, it has information on things such as when you may be able to get services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the CareSource MyCare Ohio network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan (see Section F, page 8) and for certain services (see Chapter 3, Section D *Getting care from primary care providers, specialist, other network providers, and out-of-network providers*).

You can ask for a printed *Provider and Pharmacy Directory* at any time by calling Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. You can also see the *Provider and Pharmacy Directory* at CareSource.com/MyCare, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are “network providers”?

- CareSource MyCare Ohio’s *Network Providers* include:
 - Doctors, nurses, and other health care professionals that you can go to as a member of our plan;
 - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and
 - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

For a full list of network providers, see the *Provider and Pharmacy Directory*.

- Network providers have agreed to accept payment from our plan for covered services as payment in full.
- Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, see Chapter 7, page 110.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What are “network pharmacies”?

- Network pharmacies are the pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except in an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the “Drug List” for short. It tells which prescription drugs are covered by CareSource MyCare Ohio.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, Section C, *Limits on coverage for some drugs*, for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, you can visit the plan’s website at CareSource.com/MyCare or call Member Services 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m.

Member Handbook Supplement or “Waiver Handbook”

This supplement provides additional information for members enrolled in a home and community based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount we or others on your behalf have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* is also available when you ask for one. To get a copy, please contact Member Services.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs are covered and any drug copay amounts for you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study
- If you have to see a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m.

To update your personal information on-line, go to CareSource.com/MyCare and click on "Members". Then click on My CareSource™ to open an online account.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 2: Important phone numbers and resources

This chapter provides you with a quick reference of contact information for CareSource MyCare Ohio, the State of Ohio, Medicare, and other useful resources.

Table of Contents

| | |
|---|-----------|
| A. How to contact CareSource MyCare Ohio Member Services..... | 14 |
| B. How to contact your Care Manager | 17 |
| C. How to contact the 24-Hour Nurse Advice Call Line..... | 18 |
| D. How to contact the 24-Hour Behavioral Health Crisis Line..... | 18 |
| E. How to contact the Quality Improvement Organization (QIO) | 19 |
| F. How to contact Medicare | 19 |
| G. How to contact the Ohio Department of Medicaid | 21 |
| H. How to contact the MyCare Ohio Ombudsman | 22 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. How to contact CareSource MyCare Ohio Member Services

| | |
|----------------|---|
| CALL | 1-855-475-3163 This call is free. Monday – Friday, 8 a.m. – 8 p.m. We have free interpreter services for people who do not speak English. |
| TTY | 1-800-750-0750 or 711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday – Friday, 8 a.m. – 8 p.m. |
| WRITE | CareSource P.O. Box 8738 Dayton, OH 45401-8738 If you are sending us an appeal or complaint, you can use the form (page 189) in Chapter 9, <i>What to do if you have a problem or complaint</i> . You can also write a letter telling us about your question, problem, complaint, or appeal. |
| WEBSITE | CareSource.com/MyCare |

Contact Member Services about:

- **Questions about the plan and/or your benefits**
- **Questions about claims or billing from providers**
- **Member Identification (ID) Cards**

Let us know if you didn't get your Member ID Card or you lost your Member ID Card.

- **Transportation**
Waivers members may contact their Care Manager for assistance with waiver transportation.
- **How to report fraud, waste or abuse**
- **Finding network providers**



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

This includes questions about finding or changing your primary care provider (PCP).

- **Getting long-term services and supports**

In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by Ohio Medicaid and CareSource MyCare Ohio, you may be able to get assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.

- **Understanding the information in your Member Handbook**

- **Recommendations for things you think we should change**

- **Other information about CareSource MyCare Ohio**

You can ask for more information about our plan, including information regarding the structure and operation of CareSource MyCare Ohio and any physician incentive plans we operate.

- **Coverage decisions about your health care and drugs**

A coverage decision is a decision about:

- » your benefits and covered services and drugs, **or**
- » the amount we will pay for your health services and drugs.

Call us if you have questions about a coverage decision.

► To learn more about coverage decisions, see Chapter 9, Section 4: Coverage decisions and appeals.

- **Appeals about your health care and drugs**

An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

► To learn more about making an appeal, see Chapter 9, Sections 4 – 9.

- **Complaints about your health care and drugs**

You can make a complaint about us or any provider or pharmacy. You can also make a complaint about the quality of the care you received to us or to the Quality Improvement Organization (see Section E that follows *How to contact the Quality Improvement Organization (QIO)*)).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (see the previous section *How to contact CareSource MyCare Ohio Member Services*).
- You can send a complaint about CareSource MyCare Ohio right to Medicare. You can use an online form at <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can send a complaint about CareSource MyCare Ohio directly to Ohio Medicaid. See page 21 for ways to contact Ohio Medicaid.
- You can send a complaint about CareSource MyCare Ohio to the MyCare Ohio Ombudsman. Call 1-800-282-1206. This call is free.
- To learn more about making a complaint, see Chapter 9, Section 10, *How to make a complaint*.

- **Payment for health care or drugs you already paid for**
 - For more on how to ask us to assist you with a service you paid for or to pay a bill you got, see Chapter 7, Section A, *When you can ask us to pay for your services or drugs*.
 - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Sections 4-9, for more information on appeals.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

B. How to contact your Care Manager

CareSource MyCare Ohio offers care management services to all members. Upon enrollment you will be assigned a Care Manager. Care Managers consist of Registered Nurses, Licensed Social Workers and Licensed Independent Social Workers. The Care Manager is responsible for coordinating all parts of your care. This includes long-term care and/or waiver services if you are a resident of a long-term care facility or enrolled in an HCBS waiver program. The Care Manager will be the main point of contact for your case and your Care Team.

At the time of your assessment you will meet your Care Manager and be given his/her contact information. Please allow 24 hours for a return phone call. If you are unable to reach your Care Manager or your Care Manager's supervisor after 24 hours, contact the contact our 24-hour nurse advice line.

If you would like to change your Care Manager, you, your family, caregiver, legal guardian (person appointed by a court) or authorized representative may do so during face-to-face visits with your Care Manager. You may also call or write to us to request a change.

| | |
|----------------|--|
| CALL | 1-866-206-7861 This call is free. The Care Manager call line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English. |
| TTY | 1-800-750-0750 or 711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, 365 days a year |
| WRITE | CareSource P.O. Box 8738 Dayton, OH 45401-8738 |
| WEBSITE | CareSource.com/MyCare |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

C. How to contact the 24-Hour Nurse Advice Call Line

CareSource24® is our 24-hour nurse advice line. With CareSource24, 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. CareSource24 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 an urgent illness or injury situation
- Get in contact with your Care Manager
- Get assistance with a personal crisis

| | |
|-------------|---|
| CALL | <p>1-866-206-7861 This call is free.</p> <p>CareSource24 is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.</p> |
| TTY | <p>1-800-750-0750 or 711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, 365 days a year</p> |

D. How to contact the 24-Hour Behavioral Health Crisis Line

You can also call us if you are in crisis. You can talk to someone right away and we can help you get the care you need. Just call our 24-hour behavioral health crisis line.

| | |
|-------------|---|
| CALL | <p>1-866-206-7861 This call is free.</p> <p>The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year. We have free interpreter services for people who do not speak English.</p> |
| TTY | <p>1-800-750-0750 or 711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, 365 days a year</p> |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

E. How to contact the Quality Improvement Organization (QIO)

An organization called KePRO serves as Ohio's QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KePRO is not connected with our plan.

| | |
|----------------|--|
| CALL | 1-844-455-8708 |
| WRITE | Ohio KePro Rock Run Center, Suite #100 5700 Lombardo Center Seven Hills, Ohio 44131 |
| WEBSITE | www.ohiokepro.com |

Contact KePRO about:

▪ Questions about your health care

You can make a complaint about the care you got if:

- » You have a problem with the quality of care,
- » You think your hospital stay is ending too soon, **or**
- » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

F. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

 **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

| | |
|----------------|--|
| CALL | 1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week. |
| TTY | 1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| WEBSITE | <p>http://www.medicare.gov</p> <p>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Forms, Help & Resources" and then clicking on "Phone numbers & websites."</p> <p>The Medicare website has the following tool to help you find plans in your area:</p> <p>Medicare Plan Finder: Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans."</p> <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p> |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

G. How to contact the Ohio Department of Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and copays except for prescriptions. Medicaid covers long-term care services such as home and community-based “waiver” services and assisted living services and long-term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Medicaid. CareSource MyCare Ohio provides your Medicaid covered services through a provider agreement with Ohio Medicaid. If you have questions about the help you get from Medicaid, call the Ohio Medicaid Hotline.

| | |
|----------------|---|
| CALL | 1-800-324-8680 This call is free. The Ohio Medicaid Hotline is available Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. |
| TTY | 1-800-292-3572 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Ohio Medicaid TTY number is available Monday – Friday from 7:00 am to 8:00 pm, and Saturday from 8:00 am to 5:00 pm. |
| WRITE | Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215 |
| EMAIL | bmhc@medicaid.ohio.gov |
| WEBSITE | http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx |

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address, income, or other insurance. Contact information is available online at: http://jfs.ohio.gov/County/County_Directory.pdf.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan. The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports. The MyCare Ohio Ombudsman is an independent program, and the services are free.

| | |
|----------------|---|
| CALL | 1-800-282-1206 This call is free. The MyCare Ohio Ombudsman is available Monday – Friday from 8:00 am to 5:00 pm. |
| TTY | Ohio Relay Service: 1-800-750-0750 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| WRITE | Ohio Department of Aging Attn: MyCare Ohio Ombudsman 246 N. High Street, 1st Floor Columbus, Ohio 43215-2406 |
| WEBSITE | http://aging.ohio.gov/services/ombudsman/ You can submit an online complaint at: http://aging.ohio.gov/contact/ . |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 3: Using the plan's coverage for your health care and other covered services

Table of Contents

| | |
|--|-----------|
| A. About “services,” “covered services,” “providers,” “network providers,” and “network pharmacies” | 25 |
| B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan | 25 |
| C. Your Care Team and Care Manager..... | 27 |
| D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers | 28 |
| Getting care from a primary care provider..... | 28 |
| How to get care from specialists and other network providers..... | 29 |
| What if a network provider leaves our plan? | 30 |
| How to get care from out-of-network providers | 31 |
| E. How to get long-term services and supports (LTSS)..... | 32 |
| F. How to get behavioral health services..... | 32 |
| G. How to get transportation services | 32 |
| H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster..... | 34 |
| Getting care when you have a medical emergency | 34 |
| Getting urgently needed care | 36 |
| Getting care during a disaster | 37 |
| I. What if you are billed directly for the full cost of services covered by our plan? | 37 |
| What should you do if services are not covered by our plan?..... | 38 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| | |
|---|-----------|
| J. How are your health care services covered when you are in a clinical research study? | 38 |
| What is a clinical research study? | 38 |
| When you are in a clinical research study, who pays for what? | 39 |
| Learning more | 39 |
| K. How are your health care services covered when you are in a religious non-medical health care institution?..... | 40 |
| What is a religious non-medical health care institution? | 40 |
| What care from a religious non-medical health care institution is covered by our plan?..... | 40 |
| L. Rules for owning durable medical equipment..... | 41 |
| Will you own your durable medical equipment? | 41 |
| What happens if you switch to Original Medicare? | 41 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. About “services,” “covered services,” “providers,” “network providers,” and “network pharmacies”

Services are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4, page 45.

Providers are doctors, nurses, and other people who deliver services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that deliver health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you pay nothing for covered services. The only exception is if you have a patient liability (an amount you must pay) for nursing facility or waiver services. See Chapter 4, Section A, page 43 for more information.

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. When you use a network pharmacy, you pay nothing for your prescription drugs. See Chapter 6 (Introduction and Sections A and B) for more information.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

CareSource MyCare Ohio covers health care services covered by Medicare and Medicaid. This includes behavioral health, long-term care, and prescription drugs.

CareSource MyCare Ohio will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- **The care you get must be a plan benefit.** See Chapter 4 for information regarding covered benefits, including the plan's Benefits Chart.
- **The care must be medically necessary.** *Medically necessary* means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- **The care you get must be prior authorized by CareSource MyCare Ohio when required.** For some services, your provider must submit information to CareSource



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

MyCare Ohio and ask for approval for you to get the service. This is called *prior authorization*. See the chart in Chapter 4, Sections C and D for more information.

- **You must choose a network provider to be your primary care provider (PCP) to manage your medical care.** Although you do not need approval (called a referral) from your PCP to see other providers, it is still important to contact your PCP before you see a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.
 - ➔ To learn more about choosing a PCP, see page 29.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:
 - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 34.
 - » If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. You must get prior authorization from CareSource MyCare Ohio for this care. In this situation, we will cover the care at no cost to you. To learn about getting approval to see an out-of-network provider, see page 31.
 - » The plan covers services you get at out-of-network Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the Provider and Pharmacy Directory.
 - » If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.
 - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
 - » If you are new to our plan, you may be able to continue to see your current out-of-network providers for a period of time after you enroll. This is called a "transition period." For more information, go to Chapter 1, Section F, *What to expect when you first join a health plan*, of this handbook and your *New Member Letter*.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

C. Your Care Team and Care Manager

Your Care Team includes a group of people who can help you meet your goals for a healthy life. The team includes you, your health care providers, family members or caregivers and your CareSource MyCare Ohio Care Manager. Other team members may include:

- Legal guardians
- Authorized representatives
- Home-based staff including Waiver Care Managers/Coordinators
- External community agency staff

Your Care Team may ask you questions to learn more about your health and your goals. The team will give you information to help you to understand how to care for yourself, obtain services you need, and connect with local resources. The team has your individualized needs as number one priority. The team 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.

Everyone on your Care Team works together to make sure you receive coordinated care. This means that when tests and lab work are done, the results are shared with the appropriate providers. It means that your doctors know all of the medications you are taking so they can reduce any negative effects. Your Care Manager is a key member of your Care Team. He/she will focus on integrating your care to address all your needs. He/she will encourage your participation so your goals are always at the forefront. And, your Care Manager will conduct assessments, develop treatment plans, connect you to community resources, and perform ongoing evaluations as needed.

If you would like to change your Care Manager, you, your family, caregiver, legal guardian or authorized representative may do so during face-to-face visits with your Care Manager. You may also call or write to us to request a change.

Please call us if you have any questions about care management. We are happy to assist you. All members, including those who receive long-term care and/or waiver services, can access a Care Team representative 24/7 using CareSource24. You can reach us at **1-866-206-7861**.

Your Care Manager helps you manage all of your providers and services. He or she works with your Care Team to make sure you get the care you need. The Care Manager is responsible for coordinating all parts of your care. This includes long-term care and/or waiver services if you are a resident of a long-term care facility or enrolled



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

in an HCBS waiver program and behavioral health services. The Care Manager will be the main point of contact for your case and your Care Team.

D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

Each member of CareSource MyCare Ohio must have a primary care provider (PCP) from our provider network. Your PCP is an individual physician or physician group practice trained in family practice, internal medicine, general practice, OB/Gyn, geriatrics, pediatrics, certified nurse practitioner, or physician assistant. A clinic (Rural Health Clinic/Federally Qualified Health Center) cannot be a PCP; however, a practitioner within a clinic can serve as a PCP. If you are new to our plan and in the transition period, you can continue to go to the same provider you had before you became a member. If the provider is agreeable, we will work to add him/her to our network. If not, we will work with you to find a new PCP who is in our network.

Your PCP will work with you to direct your healthcare. Your PCP will focus on your preventive care and checkups and treat you for most of your routine health care needs. He/she will coordinate most of the covered services you get from other doctors.

Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If needed, your PCP will send you to other doctors (specialists), admit you to the hospital or obtain prior authorization from CareSource MyCare Ohio for care that may require it. Although you do not need approval (called a referral) from your PCP to see other providers, it is still important to contact your PCP before you see a specialist or after you have an urgent or emergency department visit. This allows your PCP to be informed of your health changes and manage your care for the best outcomes.

Sometimes there may be a reason that a specialist may need to be your PCP. An example might be if a specialist is managing your health care for an ongoing condition that impacts your overall health. If you and/or your specialist believe that they should be your PCP, you should call the Member Services Department at **1-855-475-3163** (TTY: 1-800-750-0750 or 711) to discuss.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource MyCare Ohio ID card. It is important to try to see your PCP within your first 30 days of enrollment.

How do you choose your PCP?

The Provider Directory is a list of doctors and other health care providers who accept CareSource MyCare Ohio members. If you haven't chosen a PCP yet, please choose one right away. 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 our network, you may look in your Provider Directory if you requested a printed copy, or visit our website at **CareSource.com/MyCare** and use our Find a Doctor/Provider tool on the right side of the page. You may also call our Member Services Department at **1-855-475-3163** (TTY for the hearing impaired: 1-800-750-0750 or 711) for help. Hours are Monday – Friday, 8 a.m. – 8 p.m. 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

You may change your PCP for any reason. You can change your PCP to another network PCP as often as once a month if needed. Also, it's possible that your PCP might leave our plan's network. If your provider leaves the plan's network, we can help you find a new PCP.

If for any reason you want to change your PCP, you may call Member Services to ask for the change. If you are an existing member, you can do so through the member portal, My CareSource (see Chapter 1, Section K, *How to keep your membership record up to date*). We will process your change the date of your request. CareSource MyCare Ohio will send you a new ID card to let you know that your PCP has been changed. The Member Services Department can also help you schedule your first appointment, if needed.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

You do not need a referral from your PCP to see other providers. Some specialists may want a referral from your PCP before they see you. It is important to contact your PCP before you see a specialist. This allows your PCP to manage your care for the best outcomes. Your



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

choice of a PCP does not limit you to specific specialists or hospitals to which your PCP refers. Just check your Provider Directory for a list of specialists or other network providers and schedule an appointment yourself. If you are not sure what types of providers offer the services you need, please talk to your Care Manager.

Some services or medications may require a prior authorization from CareSource MyCare Ohio before you can get them. This means your PCP or provider must get approval from CareSource MyCare Ohio before you can get the service or drug. See the Benefits Chart in Chapter 4, Section D, for information about which services require prior authorization. Your PCP will ask for a prior authorization from us, and then schedule these services for you. If you are seeing a specialist, he/she may talk with your PCP before scheduling any services. Please see the Benefits Chart in Chapter 4, Section D, *The Benefits Chart*, for information about which services require prior authorization.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file a complaint.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Call our Member Services Department at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) for help. Hours are Monday – Friday, 8 a.m. – 8 p.m.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How to get care from out-of-network providers

The only time you can use providers that are not in our network is for:

- Emergency services or urgently needed care (prior authorization is not required)
- Care that our plan covers but there is no network provider available (prior authorization is required)
- Federally Qualified Health Centers/Rural Health Clinics
- Assisted living waiver services or long-term nursing facility services if you were receiving these services from an out-of-network provider on and before the day you became a member
- Kidney dialysis services when you are outside the service area for a short time.
- An out-of-network provider that CareSource MyCare Ohio has approved you to see during or after your transition-of-care time period
- Specialty services that are not available by a network provider

For a specified time period after your enrollment in the MyCare Ohio program, you are allowed to receive services from certain out-of-network providers and/or finish receiving services that were authorized by Ohio Medicaid. This is called your transition-of-care period. Please note, the transition periods start on the first day you are effective with any MyCare Ohio plan. If you change your MyCare Ohio plan, your transition period for coverage of a non-network provider does not start over.

You can get more information about the transition time period in Chapter 1, Section F, *What to expect when you first join a health plan*. If you are currently seeing a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services immediately (today or as soon as possible) so we can arrange the services and avoid any billing issues.

► **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you may have to pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

E. How to get long-term services and supports (LTSS)

MyCare Ohio Waiver services are designed to meet the needs of members 18 years or older, who are fully eligible for both Medicare and Medicaid, enrolled in a MyCare Ohio Plan and who are determined by the State of Ohio, or its designee, to meet an intermediate or skilled level of care. These services help individuals to live and function independently.

If you would like to see if you are eligible for waiver services, talk to your CareSource MyCare Ohio Care Manager. We will schedule your Area Agency on Aging to perform an assessment to determine if you meet the criteria for receiving these services.

F. How to get behavioral health services

If you already have a mental health care provider, we encourage you to continue seeing that provider for your treatment. If you need mental health and/or substance abuse services, please call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711). You may also self-refer directly to an Ohio Department of Mental Health and Addiction Services (MHAS) facility and/or a certified community behavioral health provider. Please see your Provider Directory, call our Member Services Department or visit our website at Caresource.com/MyCare for the names and phone number of the facilities near you. You can also call us if you are in crisis. You can talk to someone right away and we can help you get the care you need. Just call our 24-hour behavioral health crisis line at 1-866-206-7861.

G. How to get transportation services

CareSource MyCare Ohio offers transportation services, if needed. We cover up to 30 round trips per member per calendar year to any health care, Women, Infants and Children (WIC) or redetermination appointments. To arrange a ride, call CareSource MyCare Ohio at 1-855-475-3163. Dialysis transportation is provided but does not count toward your 30 round trips.

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. If you live in a long-term care facility and you require medical assistance for transport, someone who works at your facility will arrange transportation for you.

If you must travel 30 miles or more from your home to receive covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office. Please call 1-855-475-3163 to arrange a ride at least 48 hours (two business days) before your appointment. This part of the benefit is based on your location and is not subject to the 30 round-trip limit.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit Caresource.com/MyCare.

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

CareSource MyCare Ohio Transportation Guidelines

With the transportation help you get from CareSource MyCare Ohio, you can still get help through the Non-emergency Transportation (NET) program. Call your local County Department of Job and Family Services to get your questions answered or to get assistance.

To help you get the most out of CareSource MyCare Ohio's transportation services, there are guidelines you should follow. These will help you get the most out of your experience.

Please read the guidelines below to understand your responsibilities. They are for your safety and will allow you to get to your appointments on time.

Member Transportation Responsibilities

1. Members should:

- Call to arrange transportation 48 hours (two business days) in advance. *Saturday, Sunday, and holidays do not count.*
- Know the complete address of the health care provider's office that you are going to.
- Be sure your driver has enough travel time so you are not late for your appointment.
- Show your ID card to the driver before using the 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 as a "no-show".*
- Call to cancel transportation at least two hours before your scheduled pick-up time if you are unable to make your appointment.
- Ask the provider's office to call the transportation company for your return trip home.
- Ask to have your prescription filled at the provider's office before requesting your return trip call.

2. Not showing for your scheduled ride affects how we serve other members in need. To help us provide the best transportation service for you and other members, please be sure you:

- Are ready for pick-up fifteen (15) minutes before your scheduled pick-up time



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- Are ready to go when your driver arrives
- Call to cancel at least two hours before your scheduled pick-up time if you are unable to make your appointment

The transportation company has 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 ready for pick-up at least 15 minutes before your scheduled time
- Not being available for your scheduled transportation and your driver waits for 5 minutes then leaves
- You miss your scheduled transportation without cancelling at least 2 hours before the pick-up time

3. Members are expected to be courteous and show respect to the Transportation Company and CareSource MyCare Ohio staff. Improper behavior includes:

- Use of profanity (swearing), name-calling, or verbal abuse
- Threats of physical abuse to the transportation company, drivers, or CareSource MyCare Ohio staff

Please remember these guidelines as you use the transportation program. We want your transportation experiences to be positive and to meet your needs.

Please call the Member Services Department at **1-855-475-3163 (TTY: 1-800-750-0750 or 711)** if you have any questions or concerns.

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

H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical



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attention, you or any prudent layperson (meaning a person with an average knowledge of health and medicine) could expect it to result in:

- serious risk to your health; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman, in active labor, meaning labor at a time when either of the following would occur:
 - » There is not enough time to safely transfer you to another hospital before delivery.
 - » The transfer may pose a threat to your health or safety or to that of your unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital, or other appropriate setting. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP or CareSource MyCare Ohio.
- **Be sure to tell the provider that you are a CareSource MyCare Ohio member.** Show the provider your CareSource MyCare Ohio Member ID Card.
- **As soon as possible, make sure that you tell our plan about your emergency.** We want you to tell your Care Manager about your emergency care or hospitalization as soon as possible. Your Care Manager can help you. We need to follow up on your emergency care. You or your Care Manager should call to tell us about your emergency care, usually within 48 hours. Also, if the hospital has you stay, please make sure CareSource MyCare Ohio is called within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Our phone number is on the back of your CareSource MyCare Ohio member ID card.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

After the emergency is over, you may need follow-up care to be sure you get better. Please let your Care Manager know about your discharge date. Your Care Manager can help you schedule follow up appointments and get a ride, if needed. Your follow-up care will be covered by our plan. Your Care Manager can help you schedule your appointments and help with transportation, if needed. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call our plan at 1-800-488-0134.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health or the health of your unborn child was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only if*:

- you go to a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care *is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.*

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only if*:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

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, 7 days a week, or
2. Call CareSource24, our 24-hour nurse advice line, at 1-866-206-7861, or



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

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

If you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

► Our plan does not cover urgently needed care or any other care that you get outside the United States or its territories.

Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from CareSource MyCare Ohio.

Please visit our website for information on how to obtain needed care during a declared disaster: CareSource.com/MyCare.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5 for more information.

I. What if you are billed directly for the full cost of services covered by our plan?

Providers should bill us for providing you covered services. You should not get a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services as soon as possible to give us the information on the bill.

► **You should not pay the bill yourself. If you do, the plan may not be able to pay you back.**

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **see Chapter 7 to learn what to do.**



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What should you do if services are not covered by our plan?

CareSource MyCare Ohio covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (see Chapter 4), **and**
- that you get by following plan rules.

► If you get services that aren't covered by our plan, **you may have to pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have prior approval from CareSource MyCare Ohio to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are, how close you are to reaching them, and what your provider must do to ask to exceed the limit if they think it is medically necessary.

J. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study.

Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Manager should contact Member Services.

When you are in a clinical research study, who pays for what?

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study.**

Ohio Medicaid does not cover clinical research studies.

Learning more

You can learn more about joining a clinical research study by reading "Medicare and Clinical Research Studies" on the Medicare website (<http://www.medicare.gov/publications/pubs/pdf/02226.pdf>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

K. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-exceptioned."

- "Non-exceptioned" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Exceptioned" medical treatment is any care that is *not voluntary* and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

All coverage limits apply (see the Benefits Chart in Chapter 4, Section D, page 45).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

L. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. Other types of durable medical equipment will be rented for you by CareSource MyCare Ohio. Sometimes you will own the rented item after we pay the rental fee for a certain number of months, and sometimes you will not own the item no matter how long it is rented. Call Member Services to find out whether you will own your item or if it will be rented.

What happens if you switch to Original Medicare?

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. You will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

► There are no exceptions to this case when you return to Original Medicare.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 4: Benefits Chart

Table of Contents

| | |
|--|-----------|
| A. Understanding your covered services | 43 |
| B. Our plan does not allow providers to charge you for services | 43 |
| C. About the Benefits Chart..... | 44 |
| D. The Benefits Chart | 45 |
| Preventative Visits..... | 45 |
| Preventative Services and Screenings..... | 47 |
| Other Services | 51 |
| E. Accessing services when you are away from home or outside of the service area..... | 82 |
| F. Benefits covered outside of CareSource MyCare Ohio..... | 82 |
| G. Benefits <i>not</i> covered by CareSource MyCare Ohio, Medicare, or Medicaid..... | 83 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

A. Understanding your covered services

This chapter tells you what services CareSource MyCare Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, *Getting your outpatient prescription drugs through the plan* and information about what you pay for drugs is in Chapter 6, *What you pay for a one-month or long-term supply of drugs*.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. See Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan* for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m., or your Care Manager at 1-866-206-7861.

B. Our plan does not allow providers to charge you for services

Except as indicated above, we do not allow CareSource MyCare Ohio providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

➔ **You should never get a bill from a provider for a covered service. If you do, see Chapter 7 or call Member Services.**

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

C. About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your Care Manager.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.
 - ➔ If CareSource MyCare Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, see Chapter 9, Section 4, *Coverage decisions and appeals*.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, *Getting care from primary care providers, specialists, other network providers, and out-of-network providers* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a Care Team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization*. Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service. If you are not sure whether a service requires prior authorization, contact Member Services or visit our website at <https://www.caresource.com/members/ohio/caresource-mycare-ohio/my-benefits-services/>.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

D. The Benefits Chart

Preventative Visits

| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Annual checkup</p> <p>This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months.</p> <p>Note: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first.</p> | |
| <p>“Welcome to Medicare” visit</p> <p>If you have been in Medicare Part B for 12 months or less, you can get a one-time “Welcome to Medicare” preventive visit. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. This visit includes:</p> <ul style="list-style-type: none"> ■ a review of your health, ■ education and counseling about the preventive services you need (including screenings and shots), and ■ referrals for other care if you need it. | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|--|---|
| <p>Well child check-up (also known as Healthchek)</p> <p>Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. There is a recommended list of screening exams published by Bright Futures/American Academy of Pediatrics for members under age 21. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It includes immunizations, health education, and laboratory tests.</p> <p>Preventive checkups</p> <p>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 if applicable.</p> <p>Medically necessary follow-up care to treat physical, mental or other health problems or issues found during a screening, including but not limited to:</p> <p>Visits with a primary care provider, specialist, dentist, optometrist and other CareSource providers to diagnose and treat problems.</p> <p>Inpatient or outpatient hospital care</p> <p>Clinic visits</p> <p>Prescription drugs</p> <p>All covered Healthchek services are provided at no cost up to age 21.</p> <p>Transportation to and from providers and assistance with scheduling health visits is available.</p> | <p>Some services may require a referral from your PCP or prior authorization.</p> <p>If you are under 21 call your PCP to schedule an appointment for a Healthchek exam.</p> <p>Your provider may ask for prior authorization for services that have limitations or are not typically covered for members age 21 and older.</p> |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Preventative Services and Screenings

| Services covered by our plan | Limitations and exceptions |
|--|----------------------------|
| Abdominal aortic aneurysm screening The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk. | |
| Alcohol misuse screening and counseling The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner. | |
| Breast cancer screening The plan covers the following services: <ul style="list-style-type: none"> <li data-bbox="241 910 948 973">▪ One baseline mammogram between the ages of 35 and 39 <li data-bbox="241 994 915 1058">▪ One screening mammogram every 12 months for women age 40 and older <li data-bbox="241 1079 948 1184">▪ Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms <li data-bbox="241 1205 649 1237">▪ Annual clinical breast exams | |
| Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: <ul style="list-style-type: none"> <li data-bbox="241 1522 535 1554">▪ discuss aspirin use, <li data-bbox="241 1575 665 1607">▪ check your blood pressure, or <li data-bbox="241 1628 882 1660">▪ give you tips to make sure you are eating well. | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Cardiovascular (heart) disease testing</p> <p>The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.</p> | |
| <p>Cervical and vaginal cancer screening</p> <p>The plan covers pap tests and pelvic exams annually for all women.</p> | |
| <p>Colorectal cancer screening</p> <p>For people 50 and older or at high risk of colorectal cancer, the plan covers:</p> <ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy (or screening barium enema) ▪ Fecal occult blood test ▪ Screening colonoscopy <ul style="list-style-type: none"> ○ Guaiac-based fecal occult blood test or fecal immunochemical test ○ DNA based colorectal screening <p>For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).</p> | |
| <p>Counseling and interventions to stop smoking or tobacco use</p> <p>The plan covers tobacco cessation counseling and intervention.</p> | |
| <p>Depression screening</p> <p>The plan covers depression screening.</p> | |



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| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Diabetes screening</p> <p>The plan covers diabetes screening (includes fasting glucose tests).</p> <p>You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).</p> | |
| <p>HIV screening</p> <p>The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.</p> | |
| <p>Immunizations</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Vaccines for children under age 21 ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B or Medicaid coverage rules ▪ Other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D, <i>Vaccinations</i> to learn more. | |
| | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|---|---|
| <p>Lung Cancer Screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> ▪ Are aged 55-77, and ▪ Have a counseling and shared decision-making visit with your doctor or other qualified provider, and ▪ Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. | After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider. |
| <p>Obesity screening and therapy to keep weight down</p> <p>The plan covers counseling to help you lose weight.</p> | |
| <p>Prostate cancer screening</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test | |
| <p>Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B.</p> <p>The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.</p> | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Other Services

| Services covered by our plan | Limitations and exceptions |
|--|--|
| <p>Ambulance and wheelchair van services</p> <p>Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby's life or health.</p> <p>In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.</p> | <p>Prior authorization required for emergency air transport.</p> <p>Prior authorization required for non-emergent ambulance transportation.</p> <p>Prior authorization is not required for travel to and from dialysis services or from facility-to-facility</p> |
| <p>Chiropractic services</p> <p>The plan covers:</p> <ul style="list-style-type: none"> ▪ Diagnostic x-rays ▪ Adjustments of the spine to correct alignment | <p>Prior authorization required for more than 15 visits.</p> |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|--|---|
| <p>Dental services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none">▪ Comprehensive oral exam (one per provider-patient relationship)▪ Periodic oral exam once every 180 days for members under 21 years of age, and once every 365 days for members age 21 and older▪ Preventive services including prophylaxis, fluoride for members under age 21, sealants, and space maintainers▪ Routine radiographs/diagnostic imaging▪ Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services▪ One supplemental oral exam and cleaning every year | Some dental services require prior authorization. Please see your dental care provider for details. |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Diabetic services</p> <p>The plan covers the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> ▪ Training to manage your diabetes, in some cases ▪ Supplies to monitor your blood glucose, including: <ul style="list-style-type: none"> » Blood glucose monitors and test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease: <ul style="list-style-type: none"> » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) <p>The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.</p> | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|---|---|
| <p>Durable medical equipment and related supplies</p> <p>Covered durable medical equipment includes, but is not limited to, the following:</p> <ul style="list-style-type: none"> ▪ Wheelchairs ▪ Oxygen equipment ▪ Canes, crutches, and walkers ▪ IV infusion pumps ▪ Hospital beds ▪ Commodes ▪ Nebulizers ▪ Insect repellant ▪ Incontinence garments ▪ Enteral nutritional products ▪ Ostomy and urological supplies ▪ Surgical dressings and related supplies ▪ Speech generating devices <p>For additional types of supplies that the plan covers, see the sections on diabetic services, hearing services, and prosthetic devices.</p> <p>The plan may also cover learning how to use, modify, or repair your item. Your Care Team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan.</p> <p>We will cover all durable medical equipment that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.</p> | <p>Prior authorization is required for all powered and customized wheelchairs; all miscellaneous codes; and food/nutritional supplements or enteral feeds of greater than 30 cans per month.</p> <p>Prior authorization is also required for other DME categories if billed charges are greater than \$750.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Emergency care (see also “urgently needed care”)</p> <p><i>Emergency</i> care means services that are:</p> <ul style="list-style-type: none"> ▪ given by a provider trained to give emergency services, and ▪ needed to treat a medical emergency. <p>A <i>medical emergency</i> is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> ▪ serious risk to your health; or ▪ serious harm to bodily functions; or ▪ serious dysfunction of any bodily organ or part; or ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: <ul style="list-style-type: none"> » There is not enough time to safely transfer you to another hospital before delivery. » The transfer may pose a threat to your health or to that of your unborn child. <p>In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting.</p> <p>If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do.</p> <p>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.</p> | <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, contact Member Services to arrange either authorization to stay in the non-network hospital or transition of your care to a participating provider.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Family planning services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ▪ Family planning supplies (condom, sponge, foam, film, diaphragm, cap) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions ▪ Treatment for sexually transmitted infections (STIs) ▪ Treatment for AIDS and other HIV-related conditions ▪ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ▪ Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders ▪ Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) <p>Note: You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the <i>Provider and Pharmacy Directory</i>. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.</p> | <p>Prior authorization required for an abortion, and only covered if the mother's life is threatened or in case of reported rape or incest.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Federally Qualified Health Centers</p> <p>The plan covers the following services at Federally Qualified Health Centers:</p> <ul style="list-style-type: none"> ▪ Office visits for primary care and specialists services ▪ Physical therapy services ▪ Speech pathology and audiology services ▪ Dental services ▪ Podiatry services ▪ Optometric and/or optician services ▪ Chiropractic services ▪ Transportation services ▪ Mental health services <p>Note: You can get services from a network or out-of-network Federally Qualified Health Center.</p> | |
| <p>Health and wellness education programs</p> <p>Fitness support programs, including:</p> <ul style="list-style-type: none"> ▪ Fitness Center Locations ▪ Exercise classes and equipment ▪ Swimming pools and saunas at some locations ▪ In-home fitness activity kits ▪ On-line resource library ▪ Disease management materials | <p>Talk with your Care Manager for more information, visit silversneakers.com or call 1-888-423-4632</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Hearing services and supplies</p> <p>The plan covers the following:</p> <ul style="list-style-type: none">▪ Hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider)▪ Hearing aids, batteries, and accessories (including repair and/or replacement)<ul style="list-style-type: none">» Conventional hearing aids are covered once every 4 years» Digital/programmable hearing aids are covered once every 5 years | <p>Hearing aids require prior authorization.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Home and community-based waiver services</p> <p>The plan covers the following home and community-based waiver services:</p> <ul style="list-style-type: none"> ▪ Adult day health services ▪ Alternative meals service ▪ Assisted living services ▪ Choices home care attendant ▪ Chore services ▪ Community transition ▪ Emergency response services ▪ Enhanced community living services ▪ Home care attendant ▪ Home delivered meals ▪ Home medical equipment and supplemental adaptive and assistive devices ▪ Home modification, maintenance, and repair ▪ Homemaker services ▪ Independent living assistance ▪ Nutritional consultation ▪ Out of home respite services ▪ Personal care services ▪ Pest control ▪ Social work counseling ▪ Waiver nursing services ▪ Waiver transportation | <p>These services are available only if your need for long-term care has been determined by Ohio Medicaid.</p> <p>You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p> <p>Prior authorization required.</p> <p>Assisted living services – The service is limited to one visit per calendar day.</p> <p>Choices home care attendant – This service cannot be used concurrently with personal care services.</p> <p>Community transition – this service is only available if you are unable to meet such expenses or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended for purely diversion/recreational purposes. You may use this service in lieu of, but not in addition to the community transition service available through Ohio's Home Choice (MFP) demonstration program.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Home and community-based waiver services (continued)</p> | <p>Emergency Response Services</p> <ul style="list-style-type: none"> ▪ ERS does not include the following: <ul style="list-style-type: none"> *Equipment that connects you directly to 911. *Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment. *Remote monitoring services. *Services performed in excess of what is approved pursuant to your waiver services plan. *New equipment or repair of previously-approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence, ERS and the providers of such services must be identified on the waiver service plan. <p>Home Medical Equipment & Supplemental Adaptive and Assistive Devices – Device Services shall not exceed a combined total of \$10,000 within a calendar year per individual.</p> <p>Home Modification Maintenance & Repair – limited to \$10,000 per twelve-month calendar year.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| Home and community-based waiver services (continued) | Personal Care Services – The following services are not furnished at the same time the personal care assistance service is provided: home delivered meals, home care attendant service, Choices home care attendant services, assisted living, enhanced community living, and independent living assistance. |
| Home health services The plan covers the following services provided by a home health agency: <ul style="list-style-type: none"> ▪ Home health aide and/or nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Private duty nursing (may also be provided by an independent provider) ▪ Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally ▪ Medical and social services ▪ Medical equipment and supplies | Skilled Nursing home services require Prior Authorization for more than 3 visits per year. Physical Therapy home services require Prior Authorization for more than 3 visits per year. Occupational Therapy home services require Prior Authorization for more than 3 visits per year. Speech Therapy home services require Prior Authorization for more than 3 visits per year. Social worker home services require Prior Authorization for more than 2 visits per year. Prior Authorization is required for all other services, including Private Duty home services. |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Hospice care</p> <p>You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will cover the following while you are getting hospice services:</p> <ul style="list-style-type: none"> ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ▪ Nursing facility care <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare:</p> <ul style="list-style-type: none"> ▪ See Section F of this chapter for more information. <p>For services covered by CareSource MyCare Ohio but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> ▪ CareSource MyCare Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. <p>For drugs that may be covered by CareSource MyCare Ohio's Medicare Part D benefit:</p> <ul style="list-style-type: none"> ▪ Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, <i>Drug coverage in special cases</i>. | <p>If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p> <p>Prior authorization required.</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Note: Except for emergency/urgent care, if you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. If you do not know how to reach your Care Manager call 1-866-206-7861.</p> | Prior authorization required. |
| <p>Inpatient behavioral health services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital <ul style="list-style-type: none"> » For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit ▪ Inpatient detoxification care | Prior authorization required for all services including residential services. |



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| Services covered by our plan | Limitations and exceptions |
|---|--------------------------------------|
| <p>Inpatient hospital care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> ▪ Semi-private room (or a private room if it is medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Costs of special care units, such as intensive care or coronary care units ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Needed surgical and medical supplies ▪ Appliances, such as wheelchairs for use in the hospital ▪ Operating and recovery room services ▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ Blood, including storage and administration ▪ Physician/provider services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral <p><i>This benefit is continued on the next page</i></p> | <p>Prior authorization required.</p> |



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| Services covered by our plan | Limitations and exceptions |
|---|-------------------------------|
| <p>Inpatient hospital care (continued)</p> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. CareSource MyCare Ohio will arrange and/or cover transplant services at a distant location outside the service area if there are no providers within the service area and authorization is completed. If you choose to get your transplant there, we will arrange and/or cover lodging and travel costs for you and one other person if you must travel to a location outside the service area.</p> | Prior authorization required. |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Inpatient services covered during a non-covered inpatient stay</p> <p>If your inpatient stay is not reasonable and needed, the plan will not cover it.</p> <p>However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> ▪ Doctor services ▪ Diagnostic tests, like lab tests ▪ X-ray, radium, and isotope therapy, including technician materials and services ▪ Surgical dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. <p>These are devices that:</p> <ul style="list-style-type: none"> » replace all or part of an internal body organ (including contiguous tissue), or » replace all or part of the function of an inoperative or malfunctioning internal body organ. <ul style="list-style-type: none"> ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition ▪ Physical therapy, speech therapy, and occupational therapy | |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Kidney disease services and supplies</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Kidney disease education services to teach kidney care and help you make good decisions about your care ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, <i>Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan</i>. ▪ Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply <p>Note: Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.</p> | |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor.</p> <p>The plan covers three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.</p> | |



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| Services covered by our plan | Limitations and exceptions |
|--|----------------------------|
| <p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. CareSource MyCare Ohio covers the following drugs:</p> <ul style="list-style-type: none"> ▪ Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as EpoGen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases <p>➔ Chapter 5, Getting your outpatient prescription drugs through the plan, explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>➔ Chapter 6, What you pay for a one-month or long-term supply of drugs, explains what you pay for your outpatient prescription drugs through our plan.</p> | |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Mental health and substance abuse services at addiction treatment centers</p> <p>The plan covers the following services at addiction treatment centers:</p> <ul style="list-style-type: none"> ▪ Ambulatory detoxification ▪ Assessment ▪ Case management ▪ Counseling <ul style="list-style-type: none"> » Limited to 30 hours per week ▪ Crisis intervention ▪ Intensive outpatient ▪ Alcohol/drug screening analysis/lab urinalysis ▪ Medical/somatic <ul style="list-style-type: none"> » Limited to 30 hours per week ▪ Methadone administration ▪ Office administered medications for addiction including vivitrol and buprenorphine induction <p>See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information.</p> | <p>Prior authorization is required for:</p> <p>Greater than 30 intensive outpatient program visits per calendar year</p> <p>Greater than 30 partial hospitalization program visits per calendar year</p> <p>Inpatient services – see "Hospitalization"</p> <p>Prior authorization is required for all other services including Health Home and Assertive Community Treatment (ACT) services.</p> <p>Prior authorization is not required for outpatient psychiatric visits</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Mental health and substance abuse services at community mental health centers</p> <p>The plan covers the following services at certified community mental health centers:</p> <ul style="list-style-type: none"> ▪ Mental health assessment/diagnostic psychiatric interview <ul style="list-style-type: none"> » Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year ▪ Community psychiatric supportive treatment (CPST) services ▪ Counseling and therapy <ul style="list-style-type: none"> » Limited to 52 hours of combined individual/group therapy per year ▪ Crisis intervention ▪ Pharmacological management <ul style="list-style-type: none"> » Limited to 24 hours per year ▪ Pre-hospital admission screening ▪ Certain office administered injectable antipsychotic medications ▪ Partial hospitalization <ul style="list-style-type: none"> » Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. <p>See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information.</p> | <p>Prior authorization is required for:</p> <p>Greater than 30 intensive outpatient program visits per calendar year</p> <p>Greater than 30 partial hospitalization program visits per calendar year</p> <p>Inpatient services – see "Hospitalization"</p> <p>Prior authorization is required for all other services including Health Home and Assertive Community Treatment (ACT) services.</p> <p>Prior authorization is not required for outpatient psychiatric visits</p> |



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| Services covered by our plan | Limitations and exceptions |
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| <p>Nursing and skilled nursing facility care</p> <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Durable Medical Equipment, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services <p>You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment:</p> <ul style="list-style-type: none"> ▪ A nursing home or continuing care retirement community where you lived on the day you became a CareSource MyCare Ohio member <p><i>This benefit is continued on the next page</i></p> | <p>You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.</p> <p>Note that patient liability does not apply to Medicare-covered days in a nursing facility (days 1 – 100).</p> <p>Nursing and skilled nursing facilities require a prior authorization.</p> <p>Prior authorization required for physical therapy, occupational therapy and speech therapy after 30 visits.</p> |



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| Services covered by our plan | Limitations and exceptions |
|--|--|
| <p>Nursing and skilled nursing facility care (continued)</p> <p>You can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> ▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital | |
| <p>Outpatient mental health care</p> <p>The plan covers mental health services provided by:</p> <ul style="list-style-type: none"> ▪ a state-licensed psychiatrist or doctor, ▪ a clinical psychologist, ▪ a clinical social worker, ▪ a clinical nurse specialist, ▪ a nurse practitioner, ▪ a physician assistant, or ▪ any other qualified mental health care professional as allowed under applicable state laws. <p>The plan covers the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> ▪ Clinic services and general hospital outpatient psychiatric services ▪ Day treatment ▪ Psychosocial rehab services ▪ Services covered include but are not limited to: assessments & testing, pharmacy management & office visits, individual & group counseling, crisis intervention. | <p>Prior authorization is required for:</p> <p>Greater than 30 intensive outpatient program visits per calendar year</p> <p>Greater than 30 partial hospitalization program visits per year, including day treatment and psychosocial rehabilitation.</p> <p>Prior authorization is required for all other services including Health Home and Assertive Community Treatment (ACT) services.</p> <p>Prior authorization is not required for outpatient psychiatric visits</p> |

? If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|---|--|
| <p>Outpatient services</p> <p>The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury.</p> <p>The following are examples of covered services:</p> <ul style="list-style-type: none"> ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers ▪ Chemotherapy ▪ Labs and diagnostic tests (for example urinalysis) ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ▪ Imaging (for example x-rays, CTs, MRIs) ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Blood, including storage and administration ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself | <p>Prior authorization required for:</p> <p>Greater than 30 intensive outpatient program visits per calendar year</p> <p>Greater than 30 partial hospitalization program visits per calendar year</p> <p>CT, CTA, MRI, MRA and PET scans require prior authorization.</p> <p>Genetic testing requires prior authorization.</p> <p>Cosmetic procedures and plastic surgery</p> <p>Prior authorization is not required for patient psychiatric visits.</p> |



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| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Physician/provider services, including doctor's office visits</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Second opinion by another network provider before a medical procedure ▪ Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> » surgery of the jaw or related structures, » setting fractures of the jaw or facial bones, » pulling teeth before radiation treatments of neoplastic cancer, or » services that would be covered when provided by a physician. | |
| <p>Podiatry services</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma ▪ Routine foot care for members with conditions affecting the legs, such as diabetes | |



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| Services covered by our plan | Limitations and exceptions |
|--|--|
| <p>Prosthetic devices and related supplies</p> <p><i>Prosthetic devices</i> replace all or part of a body part or function. The following are examples of covered prosthetic devices:</p> <ul style="list-style-type: none"> ▪ Colostomy bags and supplies related to colostomy care ▪ Pacemakers ▪ Braces ▪ Prosthetic shoes ▪ Artificial arms and legs ▪ Breast prostheses (including a surgical brassiere after a mastectomy) ▪ Dental devices <p>The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices.</p> <p>The plan offers some coverage after cataract removal or cataract surgery. See "Vision Care" later in this section for details.</p> | <p>Prior authorization required for billed charges over \$750.</p> |



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| Services covered by our plan | Limitations and exceptions |
|--|--|
| <p>Rehabilitation services</p> <ul style="list-style-type: none"> ▪ Outpatient rehabilitation services <ul style="list-style-type: none"> » The plan covers physical therapy, occupational therapy, and speech therapy. » You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. ▪ Cardiac (heart) rehabilitation services <ul style="list-style-type: none"> » The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. » The plan also covers <i>intensive</i> cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. ▪ Pulmonary rehabilitation services <ul style="list-style-type: none"> » The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). | <p>Prior authorization required for:</p> <ul style="list-style-type: none"> • Greater than 30 occupational therapy visits • Greater than 30 physical therapy visits • Greater than 30 speech therapy visits |
| <p>Rural Health Clinics</p> <p>The plan covers the following services at Rural Health Clinics:</p> <ul style="list-style-type: none"> ▪ Office visits for primary care and specialists services ▪ Clinical psychologist ▪ Clinical social worker for the diagnosis and treatment of mental illness ▪ Visiting nurse services in certain situations <p>Note: You can get services from a network or out-of-network Rural Health Clinic.</p> | |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

| Services covered by our plan | Limitations and exceptions |
|--|---|
| <p>Specialized Recovery Services (SRS) Program</p> <p>If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to receive SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program:</p> <ul style="list-style-type: none"> ▪ Recovery Management - Recovery managers will work with you to: <ul style="list-style-type: none"> » develop a person-centered care plan which reflects your personal goals and desired outcomes, » regularly monitor your plan through regular meetings, and » provide information and referrals. ▪ Individualized Placement and Support-Supported Employment (IPS-SE) – Supported employment services can: <ul style="list-style-type: none"> » help you find a job if you are interested in working, » evaluate your interests, skills, and experiences as they relate to your employment goals, and » provide ongoing support to help you stay employed. ▪ Peer Recovery Support: <ul style="list-style-type: none"> » peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, and » goals are included in a care plan you design based on your preferences and the availability of community and supports. <p><i>This benefit is continued on the next page</i></p> | <p>If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills.</p> <p>Medically necessary mental health specialty services are covered by CareSource at no cost to the individual and no prior authorization is required.</p> <p>Prior authorization required for: Greater than 30 intensive outpatient program visits per calendar year</p> |



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| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Specialized Recovery Services (SRS) Program (continued)</p> <p>The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being and independence.</p> | |
| <p>Transportation for non-emergency services (see also “Ambulance and wheelchair van services”)</p> <p>CareSource MyCare Ohio offers transportation services, if needed. We cover up to 30 round trips per member per calendar year to any health care, Women, Infants and Children (WIC) or redetermination appointments. To arrange a ride, call CareSource MyCare Ohio at 1-855-475-3163. Please call as soon as you know you need a ride. Please call at least 48 hours (two business days) in advance.</p> <p>If you live in a long-term care facility and you require medical assistance for transport, someone who works at your facility will arrange transportation for you.</p> <p>If you <u>must</u> travel 30 miles or more from your home to get covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office. This part of the benefit is based on your location and is not subject to the 30 round-trip limit. Dialysis transportation is provided and does not count toward your 30 trips.</p> <p>► In addition to the transportation assistance that CareSource MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.</p> | |



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| Services covered by our plan | Limitations and exceptions |
|---|----------------------------|
| <p>Urgently needed care</p> <p><i>Urgently needed care</i> is care given to treat:</p> <ul style="list-style-type: none">▪ a non-emergency, or▪ a sudden medical illness, or▪ an injury, or▪ a condition that needs care right away. <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.</p> <p>Not covered outside the U.S. and its territories.</p> | |



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| Services covered by our plan | Limitations and exceptions |
|--|----------------------------|
| <p>Vision care</p> <p>The plan covers the following services:</p> <ul style="list-style-type: none"> ▪ One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: <ul style="list-style-type: none"> » per 12-month period for members under 21 and over 59 years of age; or » per 24-month period for members 21 through 59 years of age. ▪ Vision training ▪ Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: <ul style="list-style-type: none"> » Annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration » One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older. » One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) » One pair of supplemental eyeglasses (lenses and/or frames) covered every 2 years, up to \$125. | |



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E. Accessing services when you are away from home or outside of the service area

If you are away from home or outside of our service area (see Chapter 1, Section D, *What is CareSource MyCare Ohio's service area?*) and need medical care, here are suggestions for what to do:

If it's an emergency:

Call 911 or go to the nearest emergency room

If it's not an emergency:

Call your PCP for help for what to do

If you're not sure if it's an emergency:

Call your PCP or

Call CareSource24, our 24-hour nurse line. The phone number is 1-866-206-7861 (TTY: 1-800-750-0750 or 711). We can help you decide what to do.

If you need urgent care when you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover the urgently needed care you get from any provider in the United States or its territories.

F. Benefits covered outside of CareSource MyCare Ohio

The following services are not covered by CareSource MyCare Ohio but are available through Medicare. Call Member Services to find out about services not covered by CareSource MyCare Ohio but available through Medicare.

Hospice Care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.

See the Benefits Chart in Section D of this chapter for more information about what CareSource MyCare Ohio pays for while you are getting hospice care services.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by CareSource MyCare Ohio's Medicare Part D benefit:

Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, *Drug coverage in special cases*.

Note: If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Contact your Care Manager directly or call 1-866-206-7861.

G. Benefits not covered by CareSource MyCare Ohio, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits. Medicare and Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Sections 4-9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages 38-39

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- Full-time nursing care in your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.

- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).



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Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

| | |
|--|-----------|
| Introduction | 87 |
| Rules for the plan's outpatient drug coverage..... | 87 |
| A. Getting your prescriptions filled..... | 88 |
| Fill your prescription at a network pharmacy..... | 88 |
| Show your Member ID Card when you fill a prescription | 88 |
| What if you want to change a prescription to a different network pharmacy? | 88 |
| What if the pharmacy you use leaves the network?..... | 88 |
| What if you need a specialized pharmacy?..... | 88 |
| Can you use mail-order services to get your drugs?..... | 89 |
| Can you get a long-term supply of drugs? | 90 |
| Can you use a pharmacy that is not in the plan's network? | 91 |
| B. The plan's Drug List..... | 91 |
| What is on the Drug List? | 91 |
| How can you find out if a drug is on the Drug List?..... | 92 |
| What is <i>not</i> on the Drug List? | 92 |
| What are tiers? | 93 |
| C. Limits on coverage for some drugs | 93 |
| Why do some drugs have limits? | 93 |
| What kinds of rules are there? | 94 |
| Do any of these rules apply to your drugs?..... | 94 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

| | |
|---|------------|
| D. Why your drug might not be covered..... | 94 |
| You can get a temporary supply..... | 95 |
| E. Changes in coverage for your drugs..... | 97 |
| F. Drug coverage in special cases..... | 98 |
| If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan | 98 |
| If you are in a long-term care facility | 98 |
| If you are in a long-term care facility and become a new member of the plan..... | 99 |
| If you are in a Medicare-certified hospice program | 99 |
| G. Programs on drug safety and managing drugs | 100 |
| Programs to help members use drugs safely..... | 100 |
| Programs to help members manage their drugs | 100 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Introduction

This chapter explains rules for getting your *outpatient prescription drugs*. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

CareSource MyCare Ohio also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
 - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page 161 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication*. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

- To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Care Manager.

Show your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug. You should **always** show the pharmacy your Member ID Card when you fill a prescription to avoid any problems. If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

- If you need help getting a prescription filled, you can contact Member Services CareSource24 or your Care Manager.

What if you want to change a prescription to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

- If you need help finding a network pharmacy, you can contact Member Services or your Care Manager.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

- To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Care Manager.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy*. Specialized pharmacies include:



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- Pharmacies that supply drugs for home infusion therapy. Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy. If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services. Pharmacies that supply drugs requiring special handling and instructions on their use.
- ➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your Care Manager.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs that are not available through the plan's mail-order service are marked with NM (non-mail-order) or *(non-Part D drugs) in our Drug List.

Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. A 90-day supply has the same copay as a one-month supply.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, contact Member Services.

Usually, a mail-order prescription will get to you within 7-10 days. However, sometimes your mail order may be delayed. If delivery of your medication does not arrive within 10 days, please call Member Services to check on the status of your prescription. If your mail-order is delayed you can go to the pharmacy for a one-time fill. If your medication requires a prior authorization, our mail-order pharmacy will contact your doctor. If the prescription is rejected or the medication is out of stock, our mail-order pharmacy will contact you and make arrangements for a two-week supply of your medication through a local retail pharmacy. For more information about mail order, visit our website at CareSource.com/MyCare or call our Member Services Department.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. New prescriptions the pharmacy gets from you

The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. New prescriptions the pharmacy gets directly from your provider's office

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. The pharmacy may have several ways you can communicate with them. You can call the mail-order pharmacy phone number listed in the Provider and Pharmacy Directory to find out which option is best for you and let them know what you prefer.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition. Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above *Can you use mail-order services to get your drugs?* to learn about mail-order services.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- We have network pharmacies outside of our service area where you can get prescriptions filled. However, you may not be able to use a network pharmacy due to special circumstances such as an emergency or an illness or injury while travelling outside of our service area where there are no network pharmacies. Day supply and step therapy requirements still apply at out of network pharmacies. In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

If you use an out-of-network pharmacy, you may have to pay the full cost when you get your prescription.

► If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7, Section A, *When you can ask us to pay for your services or drugs*.

B. The plan's Drug List

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under your Medicaid benefits.

The Drug List includes both brand-name and generic drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at CareSource.com/MyCare. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

CareSource MyCare Ohio will *not* pay for the drugs listed in this section. These are called *excluded drugs*. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, Section 4 *Coverage decisions and appeals*.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by CareSource MyCare Ohio for free, but they are not considered part of your outpatient prescription drug benefits.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use*. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth

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- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of three (3) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

Tier 1 includes generic drugs. This is the lowest tier.

Tier 2 includes brand drugs.

Tier 3 includes non-Part D drugs covered under the Medicaid benefit.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

► Chapter 6, Section C, *What you pay for a one-month or long-term supply of drugs* tells the amount you pay for drugs in each tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

► To learn more about asking for exceptions, see Chapter 9, Section 6 Part D Drugs, *What is an exception?*

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that the generic drug will not work for you or has written “No substitutions” on your prescription for a brand-name drug or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from CareSource MyCare Ohio before you fill your prescription. If you don’t get approval, CareSource MyCare Ohio may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at CareSource.com/MyCare.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version

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you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.

- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, *What kinds of rules are there?*, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:

- is no longer on the plan's Drug List, **or**
- was never on the plan's Drug List, **or**
- is now limited in some way.

2. You must be in one of these situations:

- **You were in the plan last year and do not live in a long-term care facility.**

We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for up to a *30-day supply*. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a *30-day supply* of medication. You must fill the prescription at a network pharmacy.

- **You are new to the plan and do not live in a long-term care facility.**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for up to a *30-day supply*. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a *30-day supply* of medication. You must fill the prescription at a network pharmacy.

- **You were in the plan last year and live in a long-term care facility.**

We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. The total supply will be for up to *at least a 91-day supply and may be*

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You are new to the plan and live in a long-term care facility.**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The total supply will be for up to *at least a 91-day supply and may be up to a 98-day supply depending on the dispensing increment.* If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.**

We will cover one 31-day supply supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- Long-term care facility members receive up to a 31-day supply, unless the member presents a prescription written for less than 31 days, and they are entitled to refills (up to a 98-day supply), during the transition period. The transition period is the first 90 days on the plan, beginning on the member's effective date of coverage or when admitted into a qualified long-term care facility. Additionally, members in a qualified long-term care facility are allowed a 31-day supply, when a qualifying level-of-care change has occurred, which affects the member's ability to obtain a Part D non-formulary drug; for example, when a member's Part A coverage expires. The CareSource MyCare Ohio pharmacy benefit manager will verify the level-of-care change by confirming admission date of the member and the type of facility in which the member will reside. Assisted living facilities, retirement homes or other non-skilled group homes are not approved institutional settings and do not qualify for the long-term care transition guidelines.

► To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

OR

- **You can ask for an exception.**

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

► To learn more about asking for an exception, see Chapter 9, Section 6.2 *What is an exception?*

If you need help asking for an exception, you can contact Member Services or your Care Manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
 - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
 - » You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
 - » You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, Section 6, *Part D drugs*.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
 - » Your provider will also know about this change. He or she can work with you to find another drug for your condition.

► If there is a change to coverage for a drug you are taking, **the plan will send you a notice**. Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first *90 days* of your membership, until we have given you *at least a 91 and may be up to 98-day supply*. The first supply will be for up to a *31-day supply*, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first *90 days* in the plan.

If you have been a member of the plan for more than *90 days* and you need a drug that is not on our Drug List, we will cover one *31-day supply*. We will also cover one *31-day supply* if the plan has a limit on the drug's coverage. If your prescription is written for fewer than *31 days*, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

- To learn more about asking for exceptions, see Chapter 9, Section 6.2 *What is an exception?*

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

- To learn more about the hospice benefit, see Chapter 4, Sections D and F.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists,



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and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

- If you have any questions about these programs, please contact Member Services or your Care Manager.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Table of Contents

| | |
|---|------------|
| Introduction | 103 |
| A. The Explanation of Benefits (EOB)..... | 104 |
| B. Keeping track of your drug costs | 104 |
| 1. Use your Member ID Card. | 104 |
| 2. Make sure we have the information we need..... | 104 |
| 3. Check the reports we send you..... | 104 |
| C. You pay nothing for a one-month or long-term supply of drugs..... | 105 |
| The plan's tiers | 105 |
| Getting a long-term supply of a drug | 105 |
| How much do you pay?..... | 105 |
| D. Vaccinations | 106 |
| Before you get a vaccination | 107 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Introduction

This chapter tells you about your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under Medicaid

Because you are eligible for Medicaid, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **The plan’s *List of Covered Drugs*.** We call this the “Drug List.” It tells you:
 - » Which drugs the plan pays for
 - » Which of the three tiers each drug is in
 - » Whether there are any limits on the drugs
- **Chapter 5 of this Member Handbook.** Chapter 5 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **The plan’s *Provider and Pharmacy Directory*.** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, *Getting your prescriptions filled*.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your *out-of-pocket costs*. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your *total drug costs*. This is the amount of money you or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits*. We call it the *EOB* for short. The EOB includes:

- **Information for the month.** The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **“Year-to-date” information.** This is your total drug costs and the total payments made since January 1.

► We offer coverage of drugs not covered under Medicare. To find out which drugs our plan covers, see the Drug List.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, and that Medicare pays for you, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill, what you pay, and what Medicare pays for you.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You should give us copies of your receipts when you buy covered drugs at an out-of-network pharmacy.

► If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7 for information about what to do.

3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

C. You pay nothing for a one-month or long-term supply of drugs

With CareSource MyCare Ohio, you pay nothing for covered drugs as long as you follow the plan's rules.

The plan's tiers

Every drug in the plan's Drug's List is in one of three (3) tiers. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs include generic drugs
- Tier 2 drugs include brand drugs
- Tier 3 drugs include Medicaid covered drugs

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of three (3) tiers. You have no copays for prescription and OTC drugs on CareSource MyCare Ohio's Drug List. To find the tiers for your drugs, you can look in the Drug List.

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5, Section A, *Getting your prescriptions filled* or the *Provider and Pharmacy Directory*.

How much do you pay?

Members who have CareSource MyCare Ohio coverage for both Medicare and Medicaid have no copays for prescription drugs.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Your share of the cost when you get a *one-month or long-term* supply of a covered prescription drug from:

| *not all drugs qualify for a 90-day supply | A network pharmacy | The plan's mail-order service | A network long-term care pharmacy | An out-of-network pharmacy |
|---|--------------------------------------|--------------------------------------|--|---|
| | A one-month or up to a 90-day supply | A one-month or up to a 90-day supply | Up to a 90-day supply | Up to a 90-day supply. Coverage is limited to certain cases. See Chapter 5 for details. |
| Tier 1 | | | | |
| Part D generic drugs | \$0 | \$0 | \$0 | \$0 |
| Tier 2 | | | | |
| Part D brand drugs | \$0 | \$0 | \$0 | \$0 |
| Tier 3 Medicaid covered drugs | \$0 | \$0 | \$0 | \$0 |

► For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory*.

D. Vaccinations

Our plan covers Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with CareSource MyCare Ohio to ensure that you do not have any upfront costs for a Part D vaccine.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Table of Contents

| | |
|---|-----|
| A. When you can ask us to pay for your services or drugs..... | 109 |
| B. How to avoid payment problems | 110 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

A. When you can ask us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A *network provider* is a provider who works with the health plan.

If you get a bill for health care or drugs, call Member Services or send the bill to us. To send us a bill, see page 14, *How to contact CareSource MyCare Ohio Member Services*.

- If you have not paid the bill, we will pay the provider directly if the services or drugs are covered and you followed all the rules in the Member Handbook.
- If you have paid the bill, the services or drugs are covered, and you followed all the rules in the Member Handbook, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

► Contact Member Services or your Care Manager if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are some examples of times when you may need to ask our plan to assist you with a payment you made or a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should always tell the provider you are a member of CareSource MyCare Ohio and ask the provider to bill the plan.

- If you pay the full amount when you get the care, you can ask to have the full amount refunded. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
 - » If the provider should be paid, we will pay the provider directly.
 - » If you have already paid for the service, we will work with the provider to refund your payment.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

2. When a network provider sends you a bill

Network providers must always bill the plan for covered services.

- We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will work with the provider to refund your payment amount for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled in an emergency situation

We will cover prescriptions filled at out-of-network pharmacies in emergency situations only. Please see Chapter 3, Section H, *How to get covered services when you have a medical emergency or urgent need for care*, for descriptions of emergency situations for which an out-of-network pharmacy might be used. Examples include when you are not able to obtain medication at a network pharmacy and do not access Part D drugs at an out-of-network pharmacy on a routine basis.

You can always contact Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 189 or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at CareSource.com/Members/Ohio/MyCare/Member-Information/File-a-Complaint.

B. How to avoid payment problems

1. Always ask the provider if the service is covered by CareSource MyCare Ohio.

Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked CareSource MyCare Ohio for a coverage decision (see Chapter 9, Section 4, *Coverage decisions and appeals*), got a final decision that the service is not covered, and decided that you still want the service even though the plan does not cover it.

2. Get plan approval before seeing an out-of-network provider.

An exception to this rule is if you need out-of-network emergency or urgent care services. Another exception is if you get services at Federally Qualified Health Centers, Rural

 **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Health Clinics and qualified family planning providers listed in the Provider and Pharmacy Directory.

If you get care from an out-of-network provider, ask the provider to bill CareSource MyCare Ohio. If the out-of-network provider is approved by CareSource MyCare Ohio, you should not have to pay anything. If the out-of-network provider will not bill CareSource MyCare Ohio and you pay for the service, call Member Services as soon as possible to let us know.

- Please remember that in most situations you must get plan approval before you can see an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval as indicated above, we may not pay for services you get from an out-of-network provider. If you have questions about your transition of care period, whether you need approval to see a certain provider, or need help in finding a network provider, call Member Services.

3. Follow the rules in the Member Handbook when getting services.

See Chapter 3, Section B, for the rules about getting your health care, behavioral health, and other services. See Chapter 5 for the rules about getting your outpatient prescription drugs.

4. Use the Provider and Pharmacy Directory to find network providers.

If you do not have a Provider and Pharmacy Directory, you can call Member Services to ask for a copy or go online at CareSource.com/MyCare for the most up-to-date information.

5. Always carry your Member ID Card and show it to the provider or pharmacy when getting care.

If you forgot your Member ID Card, ask the provider to go online at CareSource.com/MyCare or to call **1-800-488-0134**. If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 8: Your rights and responsibilities

Table of Contents

| | |
|---|-----|
| Introduction | 114 |
| A. Notice about laws..... | 114 |
| B. You have a right to get information in a way that meets your needs..... | 114 |
| C. We must treat you with respect, fairness, and dignity at all times..... | 115 |
| D. We must ensure that you get timely access to covered services and drugs..... | 116 |
| E. We must protect your personal health information | 117 |
| How we protect your health information | 117 |
| You have a right to see your medical records | 118 |
| F. We must give you information about the plan, its network providers, and your covered services | 123 |
| G. Network Providers cannot bill you directly | 124 |
| H. You have the right to get your Medicare and Part D coverage from original Medicare or another Medicare plan at any time by asking for a change..... | 125 |
| I. You have a right to make decisions about your health care..... | 125 |
| You have the right to know your treatment options and make decisions about your health care | 125 |
| You have the right to say what you want to happen if you are unable to make health care decisions for yourself..... | 126 |
| What to do if your instructions are not followed..... | 130 |
| J. You have the right to make complaints and to ask us to reconsider decisions we have made..... | 130 |
| What to do if you believe you are being treated unfairly or your rights are not being respected | 130 |
| How to get more information about your rights | 131 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

| | |
|---|------------|
| K. You also have responsibilities as a member of the plan..... | 132 |
| L. Notice about Medicare as a second payer..... | 133 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs and state laws about the Medicaid program. Other federal and state laws may apply too.

B. You have a right to get information in a way that meets your needs

Each year you are in our plan, we must tell you about the plan's benefits and your rights in a way that you can understand.

- ➔ To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages.
- ➔ Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. Some written materials are available in Spanish. To request material in an alternate format or a language other than English, please call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m.
- ➔ If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can also contact the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call 7-1-1.

Español:

Cada año que usted está en nuestro plan, debemos avisarle sobre los beneficios del plan y sus derechos de una manera que usted pueda entender.

- ➔ Para obtener información de una manera que pueda entender, llame a Servicios al miembro.
- ➔ Nuestro plan tiene personas que pueden responder preguntas en diferentes idiomas.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- ➔ Nuestro plan también puede darle materiales en idiomas que no son inglés y en formatos como letras grandes, braille o audio.
- Si tiene problemas para obtener información de nuestro plan por problemas de idioma o alguna discapacidad y quiere presentar una queja, llame a Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas al día, 7 días a la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede llamar a la Línea de ayuda de Medicaid de Ohio al 1-800-324-8680, de lunes a viernes de 7:00 a.m. a 8:00 p.m. y los sábados de 8:00 a.m. a 5:00 p.m. Los usuarios de TTY deben llamar al 7-1-1.

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

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Age
- Appeals
- Behavior
- Claims experience
- Color
- Creed
- Ethnicity
- Evidence of insurability
- Genetic information
- Gender identity
- Geographic location within the service area
- Health status
- Holocaust survivors
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation. You have the right to be treated with respect and with regard for your dignity and privacy.

We cannot deny services to you or punish you for exercising your rights. Exercising your rights will not affect the way our plan, our network providers, or the Ohio Department of Medicaid treats you.

 **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- ➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also visit <http://www.hhs.gov/ocr> for more information.
- ➔ You can also call the Ohio Department of Job and Family Services Bureau of Civil Rights at 1-866-227-6353 (TTY 1-866-221-6700).
- ➔ If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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

As a member of our plan:

- You have the right to get all services that CareSource MyCare Ohio must provide and to choose the provider that gives you care whenever possible and appropriate.
- You have the right to be sure that others cannot hear or see you when you are getting medical care.
- You have the right to choose a primary care provider (PCP) in the plan's network. A *network provider* is a provider who works with the health plan.
 - » Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a network gynecologist or another network women's health specialist for covered women's health services without getting a referral. A *referral* is a written order from your primary care provider.
- You have the right to get covered services from network providers within a reasonable amount of time. This includes the right to get timely services from specialists. If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, Section D, *Getting care from primary care providers, specialists, other network providers and out-of-network providers*.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Chapter 9, Section 10, page 183 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

E. We must protect your personal health Information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- You have the right to be given information about your health. This information may also be available to someone who you have legally authorized 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.
- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, we are required to get *written permission from you first*. Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
 - » We are required to release health information to government agencies that are checking on our quality of care.
 - » We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to Federal laws.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records if it isn't to transfer the records to a new provider.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

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

Privacy Practices

This notice describes how health information about you may be used and given out. It also tells how you can get this information. Please review it carefully. The terms of this notice apply to CareSource® MyCare Ohio (Medicare-Medicaid Plan). We will refer to ourselves simply as "CareSource" in this notice.

Your Rights

When it comes to your health information, you have certain rights:

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records. You can also get other health information we have about you. Ask us how to do this.
- We will give you a copy or a summary of your health and claims records. We often do this within 30 days of your request. We may charge a fair, cost-based fee.

Ask us to fix health and claims records

- You can ask us to fix your health and claims records if you think they are wrong or not complete. Ask us how to do this.
- We may say "no" to your request. If we do, we will tell you why in writing within 60 days.

Ask for private communications

- You can ask us to contact you in a specific way, such as home or office phone. You can ask us to send mail to a different address.
- We will think about all fair requests. We must say "yes" if you tell us you would be in danger if we do not.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for care, payment, or our operations.
- We do not have to agree to your request. We may say “no” if it would affect your care or for certain other reasons.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information. This is limited to six years before the date you ask. You may ask who we shared it with and why.
- We will include all the disclosures except for those about:
 - care,
 - amount paid,
 - health care operations, and
 - certain other disclosures (such as any you asked us to make).

We will give you one list each year for free. If you ask for another within 12 months, we will charge a fair, cost-based fee.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time. You can ask even if you have agreed to get the notice electronically. We will give you a paper copy promptly.

Give CareSource consent to speak to someone on your behalf

- You can give CareSource consent to talk about your health information with someone else on your behalf.
- If you have a legal guardian, that person can use your rights and make choices about your health information. CareSource will give out health information to your legal guardian. We will make sure a legal guardian has this right and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- We will not take action against you for filing a complaint. We may not require you to give up your right to file a complaint as a condition of:
 - care,
 - payment,
 - enrollment in a health plan, or
 - eligibility for benefits.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear choice for how we share your information in the situations described below, talk to us. Tell us what you want us to do. We will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your choice, such as if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and close threat to health or safety.

In these cases we often cannot share your information unless you give us written consent:

- Marketing purposes
- Sale of your information
- Disclosure of psychotherapy notes

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in these ways:

Help you get health care treatment

- We can use your health information and share it with experts who are treating you. *Example: A doctor sends us information about your diagnosis and care plan so we can arrange more care.*

Run our company

- *We can use and give out your information to run our company and contact you when needed.*
- *We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.*



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Pay for your health care

- We can use and give out your health information as we pay for your health care. *Example: We share information about you with your dental plan to arrange payment for your dental work.*

To run our business

- We may use or share your health information to run our business.

Example: *We may use your information to review and improve the quality of health care you and others get. We may give your health information to outside groups so they can assist us with our business. Such outside groups include lawyers, accountants, consultants and others. We require them to keep your health information private, too.*

How else can we use or share your health information? We are allowed or required to share your information in other ways. These ways are often to help the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these reasons. For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

To help with public health and safety issues

- We can share health information about you for certain reasons such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting harmful reactions to drugs
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

To do research

- We can use or share your information for health research. We can do this as long as certain privacy rules are met.

To obey the law

- We will share information about you if state or federal laws require it. This includes the Department of Health and Human Services if it wants to see that we are obeying federal privacy laws.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

To respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when a person dies.

To address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities allowed by law
 - For special government functions such as military, national security, and presidential protective services

To respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order

We may also make a collection of "de-identified" information that cannot be traced back to you.

Special Rules for CareSource Members in Ohio: Ohio law requires that we get your approval in many cases before:

- giving out the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition;
- giving out information about drug and alcohol treatment you may have received in a drug and alcohol treatment program;
- giving out information about mental health care you may have received; and
- giving out certain information to Ohio's long-term care investigators.

For full information on when such approval may be needed, you can contact the CareSource Privacy Officer.

Our Responsibilities

- We protect our members' health information in many ways. This includes information that is written, spoken or available online using a computer.
 - CareSource employees are trained on how to protect member information.
 - Member information is spoken in a way so that it is not inappropriately overheard.
 - CareSource makes sure that computers used by employees are safe by using firewalls and passwords.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- CareSource limits who can access member health information. We make sure that only those employees with a business reason to access information use and share that information.
- We are required by law to keep the privacy and security of your protected health information and to give you a copy of this notice.
- We will let you know quickly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice. We must give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Effective date and changes to the terms of this notice

The original notice was effective April 14, 2003 and this version was effective September 1, 2014. 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 health information we keep. If this happens, the new notice will be available upon request and will be posted on our web site. You can also ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

The CareSource Privacy Officer can be reached by:

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

Email: HIPAAPrivacyOfficer@caresource.com

Phone: 1-800-488-0134, ext. 2023

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

As a member of CareSource MyCare Ohio, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call our Member Services Department at 1-855-475-3163 (TTY: 1-800-750-0750 or 711). This is a free service. Some written materials are available in Spanish. We can also give you information in large print, braille, or audio.

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

- **Information about how to choose or change plans**

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- **Information about our plan, including but not limited to:**
 - » Financial information
 - » How the plan has been rated by plan members
 - » The number of appeals made by members
 - » How to leave the plan
- **Information about our network providers and our network pharmacies, including:**
 - » How to choose or change primary care providers (PCP). You can change your PCP to another network PCP as often as once a month. We must send you something in writing that says who the new PCP is and the date the change began.
 - » The qualifications of our network providers and pharmacies
 - » How we pay the providers in our network

► For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at CareSource.com/MyCare.
- **Information about covered services and drugs and about rules you must follow, including:**
 - » Services and drugs covered by the plan
 - » Limits to your coverage and drugs
 - » Rules you must follow to get covered services and drugs
- **Information about why something is not covered and what you can do about it, including:**
 - » Asking us to put in writing why something is not covered
 - » Asking us to change a decision we made
 - » Asking us to pay for a bill you got

G. Network Providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

H. You have the right to get your Medicare and Part D coverage from original Medicare or another Medicare plan at any time by asking for a change

You have the right to get your Medicare health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. However, you must continue to get your Medicaid services from a MyCare Ohio plan. If you want to make a change, you can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY users should call 7-1-1), Monday – Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.

I. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand* regardless of cost or benefit coverage.

- **Know your choices.** You have the right to be told about all the kinds of treatment, provided in a way appropriate to your condition and ability to understand.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another qualified network provider before deciding on treatment. If a qualified network provider is not able to see you, we will arrange a visit with a non-network provider at no cost to you.
- **You can say “no.”** You have the right to refuse any treatment or therapy. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you say no to treatment, therapy or taking a drug, the doctor or CareSource MyCare Ohio must talk to you about what could happen and they must put a note in your medical record. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- **You can ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section 4, *Coverage decisions and appeals* tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles.** You have the right to refuse treatment from a student.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

People often 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 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.

What are my rights to choose my medical care?

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

What if I am too sick to decide? What if I cannot 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 are able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can

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

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use: a Living Will, a Do Not Resuscitate (DNR) Order, a Health Care Power of Attorney (also known as a Durable Power of Attorney for Health Care) and a Declaration for Mental Health Treatment. You fill out an advance directive while you are 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?



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

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 decision can fill one out.

Do I need a lawyer?

No, you do not need a lawyer to fill out an advance directive. However, you may want to consider having a lawyer help you prepare it.

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

Yes, if your wishes follow state law. However, 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

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 are not able to 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

A Do Not Resuscitate (DNR) Order is an order written by a doctor or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, that instructs health care providers not to do cardiopulmonary resuscitation (CPR). In Ohio, there are two types of DNR Orders: (1) DNR Comfort Care, and (2) DNR Comfort Care—Arrest. You should talk to your doctor about DNR options.

Health Care Power of Attorney

A Health Care Power of Attorney is different from other types of powers of attorney. This document talks only about a Health Care Power of Attorney, not about other types of powers of attorney. A Health Care Power of Attorney allows you to choose someone to carry



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

out your wishes for your medical care. The person acts for you if you cannot act for yourself. This could be for a short time period or for a long time period.

Who should I choose?

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

When does my Health Care Power of Attorney take effect?

The form takes effect only when you can't choose your care for yourself. 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 you, while capable, to appoint a representative to make decisions on your behalf when you lack the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. For example, you can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

What is the difference between a Health Care Power of Attorney and a Living Will?

Your Living Will explains, in writing, your wishes about the use of life-support methods if you are unable to make your wishes known. Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you cannot act for yourself.

If I have a Health Care Power of Attorney, do I need a Living Will, too?

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

Can I change my advance directives?

Yes, you can change your advance directives whenever you want. It is a good idea to look over your advance directives from time to time to make sure they still say what you want and that they cover all areas.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

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 cannot act for yourself.

Where do I get advance directive forms?

Many of the people and places that give you medical care have advance directive forms. You may also be able to get these forms from Midwest Care Alliance's website at: www.midwestcarealliance.org

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid, community health agencies or legal groups may also have advance directive forms. You can visit our CareSource.com/members/ohio/caresource-mycare-ohio/my-plan-documents-resources/. The forms are also currently available on the following website: http://proseniors.org/Law_Library/Health/Advance_Dir.html.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.

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 Health Care Power of Attorney, 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. Do not just put these forms away and forget about them. Be sure to keep a copy at home.

- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**
- The hospital 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 to fill out an advance directive or not.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Ohio Department of Health by calling 1-800-342-0553 or emailing HCCComplaints@odh.ohio.gov.

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 may register online for organ donation through the Ohio Donor Registry website: www.donatelifeohio.org*

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

Chapter 9, *What to do if you have a problem or complaint*, tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint. We will also send you a notice when you can make an appeal directly to the Bureau of State Hearings within the Ohio Department of Job and Family Services.

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

What to do if you believe you are being treated unfairly or your rights are not being respected

You are free to exercise all of your rights knowing that CareSource MyCare Ohio, our network providers, Medicare, and the Ohio Department of Medicaid will not hold it against you.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 115 you can get help in these ways:

- You can **call Member Services**.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 7-1-1), Monday – Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can **call the MyCare Ohio Ombudsman** in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday – Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2, Section H, *How to contact the MyCare Ohio Ombudsman* for more information about this organization.

How to get more information about your rights

There are several ways to get more information about your rights and to make recommendations regarding your rights and responsibilities:

- You can **call Member Services**.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m.
- You can **contact Medicare**.
 - » You can visit the Medicare website to read or download “Medicare Rights & Protections.” (Go to <http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf>.)
 - » 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 can **call the MyCare Ohio Ombudsman** in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2, *How to contact the MyCare Ohio Ombudsman*, for more information about this organization.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

K. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
 - » For details about your covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
 - » For details about your covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage you have.** We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your Member ID Card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
 - » Give them the information they need about you and your health. Learn as much as you can about your health problems. Participate in developing treatment goals and follow the treatment plans and instructions that you and your providers agree on.
 - » Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
 - » If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - » Medicare Part A and Medicare Part B premiums. For nearly all CareSource MyCare Ohio members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- » If you get any services or drugs that are not covered by our plan, you may have to pay for the service or drug.
- If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Sections 4 - 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
 - » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1, Section D *What is CareSource MyCare Ohio's service area?* tells about our service area. We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Medicaid.
 - » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you. You must also notify your County Caseworker at the local Department of Job and Family Services.

Call Member Services for help if you have questions or concerns.

L. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights to ask for a coverage decision, an appeal or make a complaint. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan.

However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter explains the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services. **You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 to help guide you through your problem.**



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Table of Contents

| | |
|--|------------|
| What's in this chapter? | 134 |
| If you are facing a problem with your health or long-term services and supports | 134 |
| Section 1: Introduction..... | 137 |
| Section 1.1: What to do if you have a problem..... | 137 |
| Section 1.2: What about the legal terms? | 137 |
| Section 2: Where to call for help | 137 |
| Section 2.1: Where to get more information and help | 137 |
| Section 3: Problems with your benefits..... | 139 |
| Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?..... | 139 |
| Section 4: Coverage decisions and appeals | 140 |
| Section 4.1: Overview of coverage decisions and appeals | 140 |
| Section 4.2: Which section of this chapter will help you? | 141 |
| Section 5: Problems about services, items, and drugs (not Part D drugs)..... | 143 |
| Section 5.1: When to use this section | 143 |
| Section 5.2: Asking for a coverage decision | 145 |
| Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs) | 147 |
| Section 5.4: State Hearings for services primarily covered by Medicaid or both Medicare and Medicaid..... | 152 |
| Section 5.5: Level 2 Appeal for services, items, and drugs (not Part D drugs) | 154 |
| Section 5.6: Payment problems | 157 |
| Section 6: Part D drugs | 159 |
| Section 6.1: What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug..... | 159 |
| Section 6.2: What is an exception? | 160 |
| Section 6.3: Important things to know about asking for exceptions | 161 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

| | |
|---|------------|
| Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception | 162 |
| Section 6.5: Level 1 Appeal for Part D drugs | 165 |
| Section 6.6: Level 2 Appeal for Part D drugs | 168 |
| Section 7: Asking us to cover a longer hospital stay..... | 170 |
| Section 7.1: Learning about your Medicare rights..... | 170 |
| Section 7.2: Level 1 Appeal to change your hospital discharge date..... | 171 |
| Section 7.3: Level 2 Appeal to change your hospital discharge date..... | 173 |
| Section 7.4: What happens if I miss an appeal deadline?..... | 174 |
| Section 8: What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon | 176 |
| Section 8.1: We will tell you in advance when your coverage will be ending | 176 |
| Section 8.2: Level 1 Appeal to continue your care | 177 |
| Section 8.3: Level 2 Appeal to continue your care | 179 |
| Section 8.4: What if you miss the deadline for making your Level 1 Appeal?..... | 180 |
| Section 9: Taking your appeal beyond Level 2 | 182 |
| Section 9.1: Next steps for Medicare services and items..... | 182 |
| Section 9.2: Next steps for Medicaid services and items | 182 |
| Section 10: How to make a complaint..... | 183 |
| Section 10.1: Internal complaints | 185 |
| Section 10.2: External complaints | 187 |
| Member Grievance/Appeal Form | 189 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. You can contact any of the following resources for help.

Getting help from CareSource MyCare Ohio’s Member Services

Member Services can help you with any problems or complaints about your health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. The call is free.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- Visit our website at CareSource.com/MyCare to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 189 of this chapter or call Member Services and ask us to mail you a form.
- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio Member ID Card, and your address and telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

CareSource
Attn: Member Grievance & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do about your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572), Monday – Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The call is free. You can also visit the Ohio Department of Medicaid website at <http://www.medicaid.ohio.gov>.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman helps you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750), Monday – Friday from 8:00 a.m. to 5:00 p.m. You can also submit an online complaint at: <http://aging.ohio.gov/contact>. The services are free.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (<http://www.medicare.gov>).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or other provider that requested the service can submit a Level 1 appeal on your behalf.
 - » If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name him or her as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your “representative.”
 - » If you want someone to be your representative, call Member Services and ask for the “Appointment of Representative” form. You can also get the form on the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at CareSource.com/MyCare. The form gives the person permission to act for you. You must give us a copy of the signed form.
 - » We will also accept a letter or other appropriate form to authorize your representative.
- You can talk to a lawyer. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

Section 3: Problems with your benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care, prescription drugs, or long-term services and supports are covered or not, the way in which they are covered, and problems related to the plan's denial of payment for items and services.)

Yes.

My problem is about benefits or coverage.

Go to **Section 4: “Coverage decisions and appeals”** on page 140.

No.

My problem is not about benefits or coverage.

Skip ahead to **Section 10: “How to make a complaint”** on page 183.

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment denials.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources listed in Section 2.1 on page 137.

Section 4.2: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separated this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section 5 on page 143** gives you information if you have problems getting medical care or items, dental or vision services, behavioral health services, long-term services and supports, and prescription drugs (but **not** Part D drugs). For example, use this section if:
 - You are not getting medical care you want, and you believe our plan covers this care.
 - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
 - **NOTE:** Only use Section 5 for problems with drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with a * (non-Part D drugs) are **not** covered by Part D. See Section 6 on page 159 for Part D drug appeals.
 - You got medical care or services you think should be covered, but we are not paying for this care.
 - You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
 - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
 - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

section of this chapter because special rules apply to these types of care. See Sections 7 and 8 on pages 170 and 176.

- **Section 6 on page 159** gives you information if you have problems about Part D drugs. For example, use this section if:
 - You want to ask us to make an exception to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
 - You want to ask us to waive limits on the amount of the drug you can get.
 - You want to ask us to cover a drug that requires prior approval.
 - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
 - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- **Section 7 on page 170** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
 - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8 on page 176** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711).

If you need other help or information, please call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical care or items, dental or vision services, behavioral health services, and long-term services and supports. You can also use this section for problems with drugs that are **not** covered by Part D. Drugs in the List of Covered Drugs with a * (non-Part D drugs) are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 145 for information on asking for a coverage decision.

2. You want us to cover a benefit that requires plan approval (also called prior authorization) before you get the service.

What you can do: You can ask us to make a coverage decision. Go to Section 5.2 on page 145 for information on asking for a coverage decision.

NOTE: See the Benefits Chart in Chapter 4 for a general list of covered services as well as information on what services require prior authorization from our plan. See the *List of Covered Drugs* to see if any drugs require prior authorization. You can also view the lists of services and drugs that require prior authorization at CareSource.com/MyCare.

3. We did not approve care your doctor wants to give you, and you think we should have.

What you can do: You can appeal our decision to not approve the care. Go to Section 5.3 on page 147 for information on making an appeal.

4. We did not approve your request to get waiver services from a specific network non-agency or participant-directed provider.

What you can do: You can appeal our decision to not approve the request. Go to section 5.3 on page 147 for information on making an appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

5. You got services or items that you think we cover, but we will not pay.

What you can do: You can appeal our decision not to pay. Go to Section 5.3 on page 147 for information on making an appeal.

6. You got and paid for services or items you thought were covered, and you want us to work with the provider to refund your payment.

What you can do: You can ask us to work with the provider to refund your payment. Go to Section 5.6 on page 157 for information on asking for payment.

7. We reduced, suspended, or stopped your coverage for a certain service or item, and you disagree with our decision.

What you can do: You can appeal our decision to reduce, suspend, or stop the service or item. Go to Section 5.3 on page 147 for information on making an appeal.

NOTE: If we tell you that previously approved services or items will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to get the services and items during the appeal. Read *“Will my benefits continue during Level 1 appeals”* on page 152.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 on pages 170 and 176 to find out more.

8. We did not make a coverage decision within the timeframes we should have.

What you can do: You can file a complaint or an appeal. Go to Section 10 on page 183 for information on making a complaint. Go to Section 5.3 on page 147 for information on making a Level 1 Appeal.

NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

9. We did not make an appeal decision within the timeframes we should have.

What you can do: You can file a complaint. Go to Section 10 on page 183 for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you have not done so already. Go to Section 5.4 on page 152 for information on asking for a State Hearing. Note that if your problem is about coverage for a Medicare service or

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

NOTE: If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (go to Section 6 for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: 1-855-475-3163 TTY: 1-800-750-0750
- You can fax us at: 1-855-489-3403
- You can write to us at:

CareSource
ATTN: Member Appeals
P.O. Box 1947
Dayton, OH 45401

➔ Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, see Section 2.1 on page 137.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid drugs within 72 hours after you asked.

We will make a standard coverage decision on all other services and items within 14 calendar days after you asked. If we don't give you our decision within 14 calendar days, you can appeal.

➔ You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a “fast coverage decision.” If we approve the request, we will notify you of our decision within 24 hours for Medicaid drugs and within 72 hours for all other services and items.

The legal term for “fast coverage decision” is “expedited determination.”

- Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-855-475-3163 or fax us at 1-855-489-3403. For details on how to contact us, go to Chapter 2, *Important phone numbers and resources*.
- You can also have your doctor or your authorized representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about refunding your payment for medical care or an item you already got.)
2. You can get a fast coverage decision *only* if the standard deadlines could *cause serious harm to your health or hurt your ability to function*. The standard deadlines are 72 hours for Medicaid drugs and 14 calendar days for all other services and items.

- **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
- If you ask for a fast coverage decision without your doctor’s support, we will decide if you get a fast coverage decision.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines instead to make our decision.
- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, see Section 10 on page 183.

If the coverage decision is Yes, when will I get the service or item?

For standard coverage decisions, we will authorize the coverage within 72 hours for Medicaid drugs and 14 calendar days for all other services and items. For fast coverage decisions, we will authorize the coverage within 24 hours for Medicaid drugs and 72 hours for all other services and items. If we extended the time needed to make our coverage decision, we will authorize the coverage by the end of that extended period.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).
- You also have the right to ask for a State Hearing if the coverage decision was for a service or item that could be covered by Medicaid (read Section 5.4 on page 152 for more information).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or other provider disagree with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. We will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

► **NOTE:** If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name him or her as your representative in writing. Read “*Can someone else make the appeal for me*” on page 149 for more information.

If you need help during the appeals process, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750). The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

NOTE: You do not have to first appeal to the plan for services or items that are covered primarily by Medicaid or by both Medicare and Medicaid. You can appeal to the plan, the Bureau of State Hearings, or both. We will send you a notice of your right to appeal to the Bureau of State Hearings when the services or items are primarily covered by Medicaid or by both Medicare and Medicaid. Read below for information on filing an appeal with the plan, and go to Section 5.4 on page 152 for information on filing an appeal with the Bureau of State Hearings.

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 90 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.

► Keep reading this section to learn about what deadline applies to your appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or other provider must contact us. You can call us at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) or write to us at the following address:

CareSource
Attn: Member Grievance & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 189. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio Member ID Card, and your address and telephone number. You should also include any information that helps explain your problem.

- For additional details on how to reach us for appeals, see Chapter 2, *How to contact Caresource MyCare Ohio Member Services, page 14.*
- You can ask us for a “standard appeal” or a “fast appeal.”

The legal term for “fast appeal” is “expedited reconsideration.”

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or our website at CareSource.com/MyCare. We will also accept a letter or other appropriate form to authorize your representative.

- ➔ If the appeal comes from someone besides you or your doctor or other provider that requested the service, we must get your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf, we must get your written authorization.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How much time do I have to make an appeal?

You must ask for an appeal **within 90 calendar days** after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

- **NOTE:** If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read *"Will my benefits continue during Level 1 appeals"* on page 152 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy by calling Member Services at 1-855-475-3163.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a “standard” appeal decision?

We must give you our answer within 15 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 183.
- If we do not give you an answer to your appeal within 15 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (see Section 5.5 on page 154). You will be notified when this happens. If your



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4 on page 154).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (see Section 10 on page 183).

- ➔ **If our answer is Yes** to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal.
- ➔ **If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5 on page 154). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4 on page 152).

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 183.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (see Section 5.5 on page 154). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4 on page 152).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (see Section 10 on page 183).

- ➔ **If our answer is Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.
- ➔ **If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5 on

 **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

page 154). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4 on page 152).

Will my benefits continue during Level 1 appeals?

Yes, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or other provider must **ask for an appeal on or before the later of the following** to continue the service during the appeal:

- Within 15 calendar days of the mailing date of our notice of action; or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) 15 calendar days pass after we notify you that we said **No** to your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

► **NOTE:** Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you also asked for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision (see Section 5.4 on page 152). If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process (see Section 5.5 on page 154).

Section 5.4: State Hearings for services primarily covered by Medicaid or both Medicare and Medicaid

You should read this section if you disagree with our coverage decision on a service or item that is primarily covered by Medicaid or both Medicare and Medicaid. You can request a State Hearing in addition to or instead of appealing to our plan.

What is a State Hearing?

A State Hearing is a meeting with you or your authorized representative, our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think our plan did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

We will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver Member Handbook for more information about your rights.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How do I ask for a State Hearing?

To ask for a State Hearing, you or your authorized representative must contact the Bureau of State Hearings **within 90 calendar days** of receiving the notice of your State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. **Remember, you do not have to ask for a Level 1 Appeal before you can ask for a State Hearing.**

- **NOTE:** If you want someone to act on your behalf, including your doctor or other provider, you must give the Bureau of State Hearings written notice saying that you want that person to be your authorized representative.

You can sign and send the State Hearing form to the address or fax number listed on the form or submit your request by e-mail to bsh@jfs.ohio.gov. You can also call the Bureau of State Hearings at 1-866-635-3748.

Can I get legal help for my State Hearing?

Yes. See Section 2.1 on page 137 for information on free legal help. Please remember, you do not need a lawyer to ask for a State Hearing.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the Bureau of State Hearings gets your request. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed, but no later than 3 working days after the Bureau of State Hearings gets your request.

How will I find out about the decision?

The Bureau of State Hearings will send you a written hearing decision in the mail.

- If the hearing decision is **Yes (sustained)** to all or part of what you asked for, the decision will clearly explain what our plan must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.
- If the hearing decision is **No (overruled)** to part or all of what you asked for, it means the Bureau of State Hearings agreed with our plan. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying **No** and will tell you that you have the right to request an Administrative Appeal. The Bureau of State Hearings must get your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued. See Section 9.2 on page 182 for more information.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Will my benefits continue during my State Hearing?

Yes, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You or your authorized representative must **ask for a State Hearing before the later of the following** to continue the service during the State Hearing:

- Within 15 calendar days of the mailing date of our notice of action; or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the State Hearing request; 2) the Bureau of State Hearings decides **No** on your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

► **NOTE:** Sometimes your benefits may continue even if the Bureau of State Hearings says **No** to your appeal. If you also asked for an appeal with our plan, you may be able to continue your benefits until the plan makes its decision (see Section 5.3 on page 147). If the service is covered by both Medicare and Medicaid, your benefits will also continue during the Medicare Level 2 appeal process (see Section 5.5 on page 154).

Section 5.5: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medicaid** service or item, the letter will remind you that you may ask for a State Hearing if you have not done so already. Remember, you can ask for a State Hearing in addition to or instead of appealing to our plan. See Section 5.4 on page 152 for information on State Hearings.
- If your problem is about a service or item that could be primarily covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will remind you that you may also ask for a State Hearing if you have not done so already. See Section 5.4 on page 152 for information on State Hearings.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item that is covered by Medicare or both Medicare and Medicaid. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-855-475-3163.

➔ The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

- » However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➔ If you had “fast appeal” at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- » However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

Will my benefits continue during Level 2 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, you can ask to continue your benefits during Medicare Level 2 appeals in some cases.

- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the Independent Review Entity (IRE).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will continue during the Level 2 appeal process with the IRE.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) the IRE decides **No** on your Level 2 Appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

➔ **NOTE:** If your problem is about a service primarily covered by both Medicare and Medicaid, sometimes your benefits may continue even if the IRE says **No** to your Medicare Level 2 Appeal. If you also asked for a Medicaid State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes its decision (see Section 5.4 on page 152).

How will I find out about the decision?

The Independent Review Entity (IRE) will send you a letter explaining its decision.

- ➔ If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- ➔ If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?

If either the Independent Review Entity or the Bureau of State Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is **No** for all or part of what I asked for, can I make another appeal?

You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the Independent Review Entity will explain additional appeal rights you may have.

See Section 9 on page 182 for more information on additional levels of appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 5.6: Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. If a provider bills you for any charges that we did not pay, that is called “balance billing.” You are never required to pay the balance of any bill for covered services.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

For more information, start by reading Chapter 7: *Asking us to pay a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will work with the provider to refund your payment.
- Or, if you haven’t paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it’s the same as saying **Yes** to your request for a coverage decision.
- If the service or item is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3 on page 147. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- If you are asking to be paid back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.
- ➔ If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.
 - If the IRE reverses our decision and says we should make payment, we must send the payment to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to the provider within 60 calendar days.
 - If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 on page 182 for more information on additional levels of appeal.
- ➔ If we answer No to your appeal and the service or item is usually covered by Medicaid, you can request a State Hearing (see Section 5.4 on page 152).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs with a * (non-Part D drugs). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with * symbol follow the process in **Section 5** on page 143.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
 - » Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Drug List)*
 - » Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan’s Drug List but we require you to get approval from us before we will cover it for you).
 - » **NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

The legal term for a coverage decision about your Part D drugs is “coverage determination.”

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Use the chart below to help you decide which section has information for your situation:

| Which of these situations are you in? | | | |
|---|--|--|--|
| Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? | Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? | Do you want to get your money back for a drug you already got and paid for? | Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? |
| You can ask us to make an exception. (This is a type of coverage decision.) Start with Section 6.2 on page 160. Also see Sections 6.3 and 6.4 on pages 161 and 162. | You can ask us for a coverage decision. Skip ahead to Section 6.4 on page 162. | You can ask to have your money refunded. (This is a type of coverage decision.) Skip ahead to Section 6.4 on page 162. | You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to Section 6.5 on page 165. |

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs or is not covered in the way you would like, you can ask us to make an “exception.”

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, *Limits on coverage for some drugs*).
 - The extra rules and restrictions on coverage for certain drugs include:
 - » Being required to use the generic version of a drug instead of the brand name drug.
 - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - » Quantity limits. For some drugs, we limit the amount of the drug you can have.

Section 6.3: Important things to know about asking for exceptions

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 on page 165 tells how to make an appeal if we say **No**.

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-475-3163.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

Read Section 2 on page 137 to find out how to give permission to someone else to act as your representative.

- ➔ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you paid for a drug that you think should be covered, read Chapter 7 of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor’s statement.
 - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)
 - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
 - » If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.

If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead. We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a “fast complaint” and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section 10 on page 183.

At a glance: How to ask for a coverage decision about a Part D drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

► Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

The legal term for “fast coverage decision” is “**expedited coverage determination**. ”

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

→ **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your request.

→ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

→ **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor’s or prescriber’s supporting statement.

→ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Deadlines for a “standard coverage decision” about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is Yes** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said No. The letter will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-475-3163.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan “redetermination.”

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-855-475-3163.
 - » If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 on page 162.

The legal term for “fast appeal” is “expedited redetermination.”

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

➔ **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

► **If our answer is Yes** to part or all of what you asked for:

- » If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.
- » If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.

► **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 6.6: Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will automatically send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-855-475-3163.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

► Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is “reconsideration.”



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”
- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
 - » If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
 - » If the IRE approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE with the decision of your Level 2 appeal will tell you the dollar value needed to continue with the appeal process.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights*. If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 1-855-475-3163. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The *Important Message* tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-855-475-3163. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

You can also see the notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

- If you need help, please call Member Services or Medicare at the numbers listed above.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

In Ohio, the Quality Improvement Organization is called KEPERO. To make an appeal to change your discharge date, call KEPERO at: 1-844-455-8708.

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask for a “fast review.”

Call before you leave the hospital and before your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 on page 174.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at 1-855-475-3163. You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

Ask for a “fast review”

You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

*The legal term for “fast review” is “**immediate review**.”*

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

*The legal term for this written explanation is called the “**Detailed Notice of Discharge**.” You can get a sample by calling Member Services at **1-855-475-3163**. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>*

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Ohio, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-844-455-8708.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different*.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes to your fast review**, it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- ➔ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 183 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only when they are covered by Medicare*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the *Notice of Medicare Non-Coverage*.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying the cost for your care.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 on page 183 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at 1-855-475-3163. Or call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Ohio, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-844-455-8708. Information about appealing to the Quality Improvement Organization is also in the *Notice of Medicare Non-Coverage*. This is the notice you got when you were told we would stop covering your care.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 on page 180.

The legal term for the written notice is “Notice of Medicare Non-Coverage.”

To get a sample copy, call Member Services at 1-855-475-3163 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is “Detailed Explanation of Non-Coverage.”

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

In Ohio, the Quality Improvement Organization is called KEPERO. You can reach KEPERO at: 1-844-455-8708. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-844-455-8708 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different*.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say No to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a “fast review.”

We will give you our decision within 72 hours.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.
- ➔ To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “expedited appeal.”

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 on page 183 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

Section 9.2: Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at 1-866-635-3748.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only*, such as problems related to quality of care, waiting times, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential*.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- CareSource MyCare Ohio staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section 10.2 on page 187.

► If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about receiving a bill

- Your doctor or provider sent you a bill.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).**

The legal term for a “complaint” is a “grievance.”

The legal term for “making a complaint” is “filing a grievance.”



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Section 10.1: Internal complaints

To make an internal complaint, call Member Services at 1-855-475-3163. Complaints related to Part D must be made **within 60 calendar days** after you had the problem you want to complain about. All other complaints must be made **within 90 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can also use the form on page 189 to submit the complaint.
- Specifically if you would like to file a complaint, you can do so in any of the following ways:
 - Call Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711). Monday – Friday, 8 a.m. – 8 p.m., or
 - Fill out the Member Grievance/Appeal form available online or on page 189, 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 MyCare Ohio member ID card, and your address and telephone number in the letter so that we can contact you, if needed. Please send any information that helps explain your problem.

Mail the form or your letter to:

CareSource
ATTN: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

- If your grievance is about getting a bill for care you or a family member received, please call the telephone number on the bill to make sure they have your CareSource MyCare Ohio ID number or to give them the primary insurance for the family member who received the care. If they tell you they have this information, please ask them why you are receiving a bill.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

- After you have done this, please contact our Member Services Department and provide us with the following information on your bill:
 - The date of service
 - The amount of the bill
 - The provider's name
 - The telephone number
 - The account number
 - Tell us why the provider's office told you they were billing you

- If you are not happy with our answer to your grievance, please contact our Member Services Department, and we will be happy to discuss it with you.

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

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-324-8680

- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal", we will automatically file a "fast complaint" for you and respond to your complaint within 24 hours.

The legal term for "fast complaint" is "expedited grievance."

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services’ Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit <http://www.hhs.gov/ocr> for more information.

You may also contact the local Office for Civil Rights office at:

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act and under Ohio Revised Code 4112.02. You can contact Member Services at 1-855-475-3163 (TTY: 1-800-750-0750 or 711) or the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572) for assistance.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

You can file a complaint with the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

In Ohio, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-844-455-8708.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Member Grievance/Appeal Form

Ohio

Member Name

Member ID #

Member Address

Member Telephone

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)

OFFICE USE ONLY

Action taken to resolve grievance/appeal:

Date Received:

Grievance Level 1 2

Hearing Date:

(signature plan rep) (resolution date)



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

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If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Request for Redetermination of Medicare Prescription Drug Denial

Because CareSource® MyCare Ohio (Medicare-Medicaid Plan) denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

Address: **Fax Number:**
CVS Caremark 1-855-633-7673
MC 109
P.O. Box 52000
Phoenix, AZ 85072-2000

You may also ask us for an appeal through our website at CareSource.com/MyCare. Expedited appeal requests can be made by phone at 1-855-475-3163.

Who May Make a Request: Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Requestor's Relationship to Enrollee

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.

Prescription drug you are requesting:

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? Yes No

If "Yes":

Date purchased: _____ Amount paid: \$ _____ (attach copy of receipt)

Name and telephone number of pharmacy:

Prescriber's Information

Name

Address

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. For more information, visit CareSource.com/MyCare.

Important Note: Expedited Decisions

If you or your prescriber believe that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS

If you have a supporting statement from your prescriber, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage.

Signature of person requesting the appeal (enrollee, or the enrollee's prescriber or representative):

Date: _____

CareSource MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Limitations, copays, and restrictions may apply. For more information call CareSource MyCare Ohio Member Services or read the Member Handbook.

Benefits, Lists of Covered Drugs, pharmacy and provider networks and/or copayments may change from time to time throughout the year and on January 1 of each year.

H8452_OHMMC226

File and Use 4/22/2014



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 10: Changing or ending your membership in our MyCare Ohio Plan

Table of Contents

| | |
|--|------------|
| Introduction | 195 |
| A. When can you change or end your membership in our MyCare Ohio plan? | 195 |
| B. How do you change or end your membership in our plan?..... | 196 |
| C. How do you join a different MyCare Ohio plan? | 196 |
| D. If you do not want a different MyCare Ohio plan, how do you get Medicare and Medicaid services? | 196 |
| How you will get Medicare services | 197 |
| How you will get Medicaid services..... | 198 |
| E. Until your membership changes or ends, you will keep getting your Medicare and Medicaid services through our plan..... | 199 |
| F. Your membership will end in certain situations..... | 199 |
| G. We <i>cannot</i> ask you to leave our plan for any reason related to your health..... | 200 |
| H. You have the right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan..... | 200 |
| I. Where can you get more information about ending your plan membership? | 200 |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan.

A. When can you change or end your membership in our MyCare Ohio plan?

You can ask to change or end your membership in CareSource MyCare Ohio at any time.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request. Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you ask to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.
- If you ask to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

These are ways you can get more information about when you can change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

B. How do you change or end your membership in our plan?

If you decide to change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 197.

See Section A on previous page for information on when your request to change or end your membership will take effect.

C. How do you join a different MyCare Ohio plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different MyCare Ohio plan.

To enroll in a different MyCare Ohio plan:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.

If you make a request to switch to a different MyCare Ohio plan before the last five days of a month, your coverage with CareSource MyCare Ohio will end on the last day of that same month. If you make a request to switch to a different MyCare Ohio plan on one of the last five days of a month, your coverage with CareSource MyCare Ohio will end on the last day of the following month. See Section A on previous page for more information about when you can change or end your membership.

D. If you do not want a different MyCare Ohio plan, how do you get Medicare and Medicaid services?

If you do not want to enroll in a different MyCare Ohio plan, you will go back to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by CareSource MyCare Ohio.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan.

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| <p>1. You can change to:</p> <p>A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage</p> | <p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your new plan's coverage begins.</p> |
| <p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p> | <p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You can select a Part D plan at this time.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your Original Medicare and prescription drug plan coverage begins.</p> |



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

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| <p>3. You can change to:</p> <p>Original Medicare <i>without</i> a separate Medicare prescription drug plan</p> <p>NOTE: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.</p> <p>You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source.</p> | <p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none">Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. <p>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your Original Medicare coverage begins.</p> |
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How you will get Medicaid services

You must get your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you do not want to get your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from CareSource MyCare Ohio or another MyCare Ohio managed care plan.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care. See Chapter 4, Section D, *The Benefits Chart*, page 45 for more information.

Once you stop getting Medicare services through our plan, you will get a new Member ID Card and a new *Member Handbook* for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

E. Until your membership changes or ends, you will keep getting your Medicare and Medicaid services through our plan

If you change or end your enrollment with CareSource MyCare Ohio, it will take time before your new coverage begins. See page 195 for more information. During this time, you will keep getting your Medicare and Medicaid services through our plan.

- **You should use our network pharmacies to get your prescriptions filled.**

Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.

If you are hospitalized on the day that your membership changes or ends, your hospital stay will be covered by our plan until you are discharged. This will happen even if your new health coverage begins before you are discharged.

F. Your membership will end in certain situations

These are the cases when Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
 - If you are away from our service area for more than six months or you establish primary residence outside of Ohio. If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.

You must be a United States citizen or lawfully present in the United States to be a member of our plan. The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis. We must disenroll you if you don't meet this requirement.

We can ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

? **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members.
- If you let someone else use your Member ID Card to get medical care.
 - » If your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

G. We cannot ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

You should also call the Ohio Medicaid Hotline at 1-800-324-8680, Monday – Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.

H. You have the right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your membership. You can also see Chapter 9, Section 10 for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when Medicare and Medicaid can end your membership, you can call Member Services at 1-855-475-3163.



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Chapter 11: Definitions of important words

Advance directive: A legal document that you can use to give directions about your future health care in case you become unable to make health care decisions for yourself. Examples are a *living will* and a *power of attorney for health care*. (See Chapter 8, Section I, *You have a right to make decisions about your health care*.)

Care Manager: A person who works with you, with CareSource MyCare Ohio, and with your care providers to make sure you get the care you need. (See Chapter 1, Section C, *What are the advantages of this plan?*)

Care plan: The plan for what health services you will get and how you will get them. Your Care Team will work with you to make and continuously update your care plan to address the health services you need and want. (See Chapter 1, Section G, *What is a care plan?*)

Care Team: Doctors, nurses, counselors or other health professionals who are there to help you get the care you need. The Care Team and Care Manager will work with you to come up with a care plan specifically designed to meet your needs. The Care Team will be in charge of coordinating the services you need. (See Chapter 1, Section C, *What are the advantages of this plan?*)

Covered services: The general term we use to mean all of the health care, long- term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services that our plan pays for. (See Chapter 3, Section A, *About "services," "covered services," "providers," "network providers," and "network pharmacies."*)

Durable medical equipment: Certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers and hospital beds. (See Chapter 3, Section L, *Rules for owning durable medical equipment*.)

Explanation of Benefits (EOB): A summary report that we send you when you use your MyCare benefits to verify the services or drugs you receive. The EOB for prescription drugs helps you understand and keep track of payments for your Part D drugs. It tells you the total amount we have paid for each of your Part D prescription drugs during the month. (See Chapter 1, Section J, *What other information will you get from us?*)

Guardian: A person appointed by a court to be legally responsible for another person. A court appoints a guardian to manage the personal affairs of an adult who can no longer make safe and sound decisions by themselves due to a legal or mental incapacity. A minor may also have a guardian appointed by a court in certain situations. Only a court may appoint a guardian. The court that usually appoints a guardian is your local probate court. It may be different depending



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

upon where you live. Contact your local court, a local attorney or local legal aid service for more information on guardianship. (See Chapter 2, Section B, *How to contact your Care Manager.*)

Health Care Power of Attorney (POA): A Health Care Power of Attorney is a legal document that allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you cannot act for yourself. A Health Care POA is sometimes called a Durable Power of Attorney for Health Care. (See Chapter 8, Section I, *You have the right to make decisions about your health care.*)

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social and spiritual needs. CareSource MyCare Ohio must give you a list of hospice providers in your geographic area. (See Chapter 4, Section D, *The Benefit Chart.*)

List of Covered Drugs (Formulary or “Drug List”): A list of prescription drugs that are covered by our plan. The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. (See Chapter 1, Section J, *What other information will you get from us?*)

Long term support services: Sometimes referred to as waiver services, these include things such as home delivered meals, emergency response services and adult day care. These are services to help eligible members live independently. (See *Handbook Introduction*, page 1.)

Medicaid: Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules. (See Chapter 1, Section B, *What are Medicare and Medicaid?*)

Medically necessary: The services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. (See Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan.*)

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure). (See Chapter 1, Section B, *What are Medicare and Medicaid?*)

 **If you have questions**, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Medicare-Medicaid plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and Care Teams to help you manage all your providers and services. They all work together to provide the care you need. (See Chapter 1, Section A, *Welcome to CareSource MyCare Ohio*.)

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances and appeals. (See Chapter 2, Section A, *How to contact Care Source MyCare Ohio Member Services*.)

Network pharmacies: The pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. Except in an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy. (See Chapter 1, Section J, *What other information will you get from us?*)

Network providers: Doctors, nurses and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers and others who provide goods and services that you get through Medicare or Medicaid. Network providers have agreed to accept payment from our plan for covered services as payment in full. For a full list of network providers, see the *Provider and Pharmacy Directory*. (See Chapter 1, Section J, *What other information will you get from us?*)

Patient Liability: This is the amount you must pay toward your long term care services while living in a facility. (See Chapter 3, Section A, *Using the plan's coverage for your health care and other covered services*.)

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. (See Chapter 3, Section D, *Getting care from primary care providers, specialists, other network providers, and out-of-network providers*.)

Prior authorization: Approval in advance to get certain services or drugs. Your provider must submit information to CareSource MyCare Ohio and request approval for you to receive the service. (See Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan*.)

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

ostomy supplies and enteral and parenteral nutrition therapy. (See Chapter 3, Section L, *Rules for owning durable medical equipment.*)

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription. (See Chapter 5, Section D, *Why your drug might not be covered.*)

Service area: The geographic area where our health plan accepts members based on where people live. The plan may disenroll you if you permanently move out of the plan's service area. (See Chapter 1, Section D, *What is CareSource MyCare Ohio's service area?*)

Specialist: A doctor who provides health care for a specific disease or part of the body. For example, oncologists (care for patients with cancer) or cardiologists (care for patients with heart problems). (See Chapter 3, Section D, *Getting care from primary care providers, specialists, other network providers, and out-of-network providers.*)

Step therapy: A rule that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed. This may apply to some of the drugs on our Drug List. (See Chapter 5, Section C, *Limits on coverage for some drugs.*)



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

CareSource MyCare Ohio Member Services

CALL 1-855-475-3163

Calls to this number are free. Monday – Friday, 8 a.m. – 8 p.m.

Member Services also has free language interpreter services available for non-English speakers.

TTY 1-800-750-0750 or 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. Monday – Friday, 8 a.m. – 8 p.m.

WRITE CareSource
P.O. Box 8738
Dayton, OH 45401-8738

Send appeals to:
CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

WEB SITE CareSource.com/MyCare

Did you know?

You can sign up for a personal online account that can help you get the most out of your member experience. With My CareSource™ you can:

- Change your doctor
- Request a new ID card
- View claims and plan details
- And more

To sign up just visit MyCareSource.com



If you have questions, please call CareSource MyCare Ohio at 1-855-475-3163 (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your Care Manager, please call 1-866-206-7861, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit CareSource.com/MyCare.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-475-3163. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-475-3163. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电1-855-475-3163。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電1-855-475-3163。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-475-3163. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-475-3163. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-475-3163 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-855-475-3163. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-475-3163 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-475-3163. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي سؤال تتعلق بالصحة أو جدول الأدوية لدينا.
للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-475-3163. سبقوم شخص ما
بمساعدتك. هذه خدمة مجانية يتحدث العربية.

Hindi:

हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-475-3163 पर फोन करें।
कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-475-3163. Un nostro incaricato che parla Italiano fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-475-3163. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-475-3163. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-475-3163. Ta usługa jest bezpłatna.

Japanese:

当社の健康健康保険と薬品処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-855-475-3163 にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Non-Discrimination Notice

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call CareSource at 1-844-607-2835.

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254
CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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



CareSource MyCare Ohio
Member Services Department:
1-855-475-3163 (TTY: 1-800-750-0750 or 711)
CareSource.com/MyCare

