WORKING WITH CARESOURCE

HEALTH PARTNER ORIENTATION

GEORGIA MARKETPLACE AND DUAL-ELIGIBLE SPECIAL NEEDS PLAN (D-SNP)

CareSource®

About CareSource

CareSource®

Our Mission

MISSION

To make a lasting difference in our members' lives by improving their health and well-being

PLEDGE

- Make it easier for you to work with us
- Partner with you to help members make healthy choices
- Provide direct communication
- Timely and low-hassle medical reviews
- Accurate and efficient claims payment

Health Care with Heart

MISSION-FOCUSED

Comprehensive, member-centric health and life services

EXPERIENCED

With over 30 years of service, CareSource is a leading non-profit health insurance company

DEDICATED

We serve over 2.1 million members through our Medicaid, Marketplace, MyCare, Dual-Eligible Special Needs Plans (D-SNP) and Arkansas PASSE programs

Our Plans

MEDICAID

Children, Pregnant Women & Low-Income Working Families

Risk-based managed care; Aged, Blind & Disabled (ABD) populations; Healthy Start & Healthy Families population

MYCARE OHIO

Medicaid & Medicare-Eligible

Coordination of physical, behavioral & long-term care services

MARKETPLACE

Commercial Health Plan

Reduced premiums or cost-sharing; Pediatric Dental & Vision; Optional Adult Dental, Vision and Fitness

DUAL ADVANTAGE

Dual-Eligible Special Needs (D-SNP) Plan

Combines benefits of Medicare and Medicaid; Adds additional benefits outside of Medicare and Medicaid plans

CareSource Expectations of Providers

- Primary Care Providers (PCPs) only - provide 24-hour availability to your CareSource patients by telephone
- Notify CareSource of any demographic changes prior to the effective date of the change
  - 10 to 60 days depending on the type of change (refer to the Provider Manual)
- Provide notification to terminate the contract 90 days in advance of desired termination
- Do not balance bill CareSource members
- Comply with access and availability standards
- Provide medical records upon request
- Submit claims or corrected claims within 180 days of date of service or date of discharge
- Treat CareSource members with respect
- Complete model of care training (D-SNP providers)

Please refer to your contract and the Provider Manual for more information on provider expectations and responsibilities.

Working with CareSource

CareSource®

Provider Network & Eligibility

CareSource Medicaid members choose or are assigned a primary care provider (PCP) upon enrollment. When referring patients, ensure other providers are in-network to ensure coverage. Use our Find-a-Doc tool at **CareSource.com** to help you locate a participating CareSource provider by plan.

OUT OF NETWORK SERVICES

Out-of-network services are NOT covered unless they are emergency services, services covered by the No Surprises Act, or services prior authorized by CareSource.

MEMBER ELIGIBILITY

Be sure to ask to see each patient's CareSource member ID card to ensure you take their plan. Be sure to confirm which CareSource plan the member is asking that you accept.

Provider Directory Attestation

Accurate provider directory information ensures we can connect the right patients to the right provider.

CMS requires health plans to verify the accuracy of provider directory information **every 90 days.**

We have partnered with Quest Analytics to streamline your verification process through their **BetterDoctor solution**.

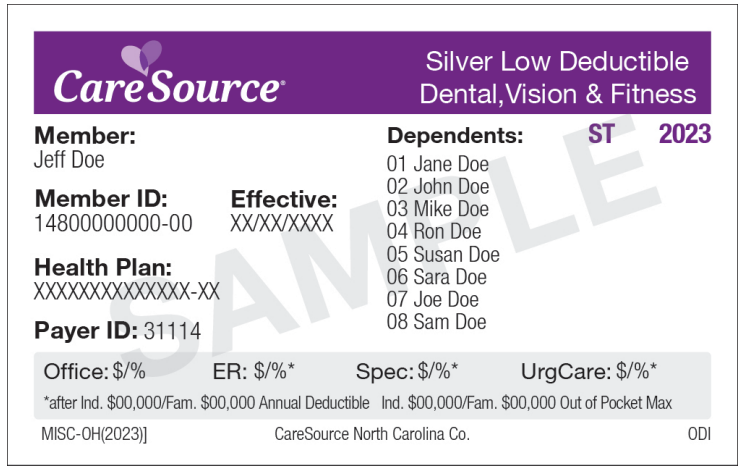
QUEST ANALYTICS BetterDoctor

Completing the Attestation Process:

1. You should receive an email or fax from BetterDoctor.
2. Go to: betterdoctor.com/validate.
3. Locate the access token on the fax or email you received from BetterDoctor (it is an 8-character alphanumeric code (for example ABC123D4), and it is not case sensitive).
4. Enter the access token.
5. Click 'Submit.'
6. Verify and update your information using the online tool via the BetterDoctor portal.
7. Larger practices can submit rosters directly to Quest Analytics.

Issues? Contact **support@betterdoctor.com**

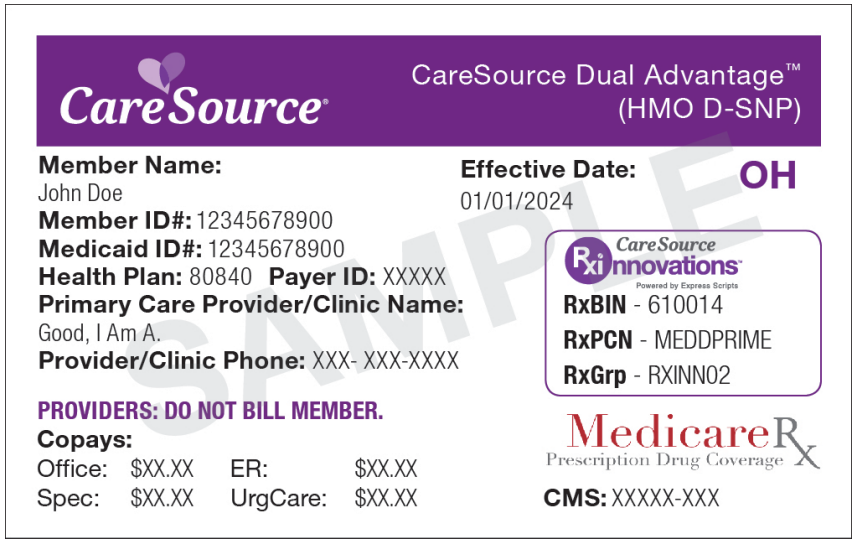
ID Cards: Marketplace Members

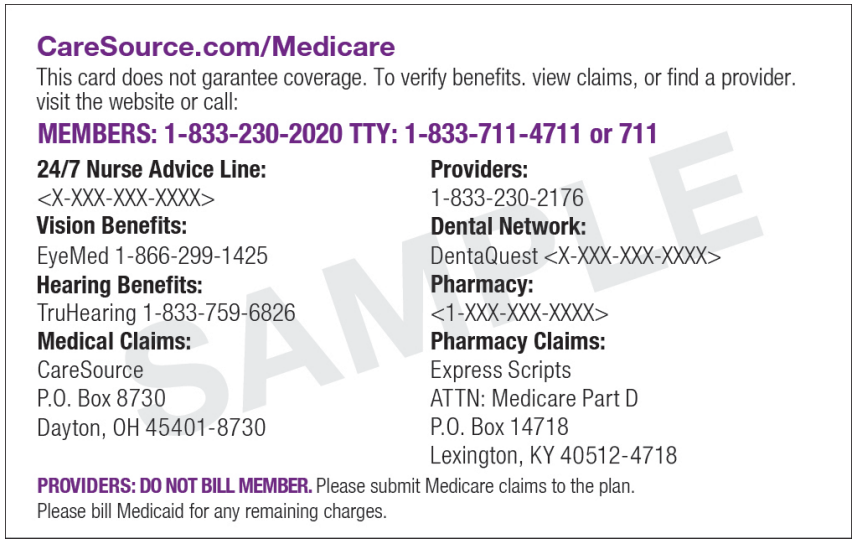


Note: Make sure the state matches your contracted region.
Marketplace dependents are indicated by the member ID + dependent suffix (portion after the “-”)

- Example: 14800000000-01 (Jane Doe)

ID Cards: D-SNP Members





Claim Submissions

ELECTRONIC CLAIM SUBMISSIONS

CareSource encourages electronic claim submission as the primary submission method. We partner with ECHO Health for electronic funds transfer (EFT). You must enroll with ECHO Health to participate. Find the enrollment form for ECHO Health online at: www.echohealthinc.com. For questions, call ECHO Support at: 1-888-485-6233.

ALTERNATE SUBMISSION PROCESS

Providers can submit claims through our secure, online Provider Portal at **CareSource.com** > Provider Log-In.

CLEARINGHOUSES

For electronic data interchange (EDI) transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can find a list of EDI vendors online at: https://www.availity.com/ediclearinghouse.

Access and Availability

As a CareSource provider, you must ensure your practice complies with the following minimum access standards:

- Provide **24-hour availability** to your CareSource patients by telephone.
    - Whether through an answering machine or a taped message after hours, patients should have the means to contact their PCP or back-up provider to be triaged for care.
    - Return urgent care calls within 20 minutes and all other calls within one hour.
    - It is not acceptable to use a phone message that doesn't provide access to you or your back-up provider and only recommends an emergency room after hours.

Please refer to our Provider Manual at **CareSource.com** > Providers > Tools & Resources > Provider Manual for a complete listing of Access and Availability Standards.

Access and Availability

Primary Care Providers (PCPs) **Marketplace Members**

Type of Visit	Should be seen…
Emergency needs	**Immediately upon presentation**
Urgent care*	**Not to exceed 48 hours**
Regular and routine care	**Not to exceed 6 weeks**

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

Access and Availability

Non-PCP Specialists **Marketplace Members**

Type of Visit	Should be seen…
Emergency needs	**Immediately upon presentation**
Urgent care*	**Not to exceed 48 hours**
Regular and routine care	**Not to exceed 12 weeks**

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

Access and Availability

Behavioral Health Providers **Marketplace Members**

Type of Visit	Should be seen…
Emergency needs	**Immediately upon presentation**
Non-life-threatening emergency*	**Not to exceed 6 hours**
Urgent care*	**Not to exceed 48 hours**
Initial visit for routine care	**Not to exceed 14 calendar days**
Follow-up routine care	**Not to exceed 30 calendar days based off the condition**

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.

Member Communications

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

Encourage your patients to visit **CareSource.com**, where they can access:

- MyCareSource.com Member Portal
- Searchable online formulary and prescription cost calculator
- Find-a-Doc tool
- Evidence of Coverage & Schedule of Benefits
- Member Handbook
- Total Cost Navigator
- Forms and more

For more information, visit: **CareSource.com/members.**

Communicating with Us

	Marketplace	D-SNP
Provider Services	**1-833-230-2101**	**1-833-230-2176**
Hours	Monday – Friday 8 a.m. – 6 p.m. Eastern Time (ET)	
Member Services	**1-833-230-2030**	**1-833-230-2020**
Hours	Monday – Friday, 7 a.m. – 7 p.m. ET	Monday – Friday, 8 a.m. – 8 p.m. ET from Oct. 1 – March 31, we are open the same hours 7 days a week

Provider Portal

CareSource®

CareSource Provider Portal

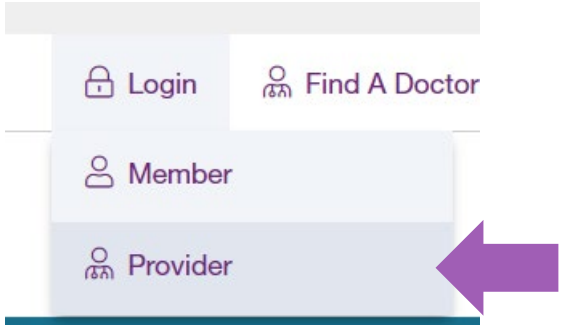
SAVE TIME AND MONEY

With CareSource's secure online Provider Portal, you can:

- ✓ Check member eligibility and benefit limits
- ✓ Find prior authorization requirements
- ✓ Submit prior authorization request and check status
- ✓ Submit claims and verify claim status
- ✓ Verify or update Coordination of Benefits
- ✓ And more!

Access the Provider Portal 24 hours a day, 7 days a week at **CareSource.com** > Provider > Login.

Register for the Provider Portal

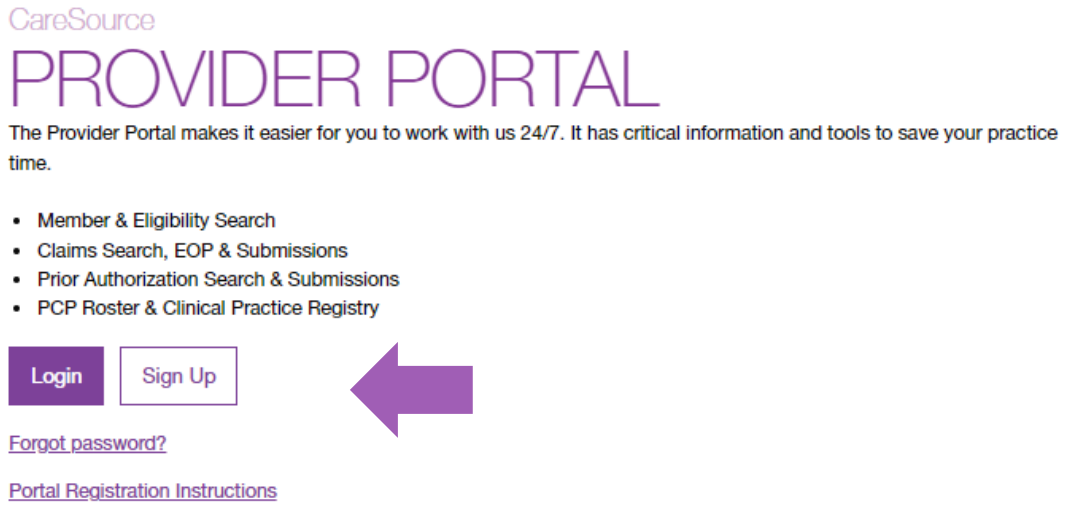


1. Go to **“Sign Up”** to establish your account by creating your username and password.

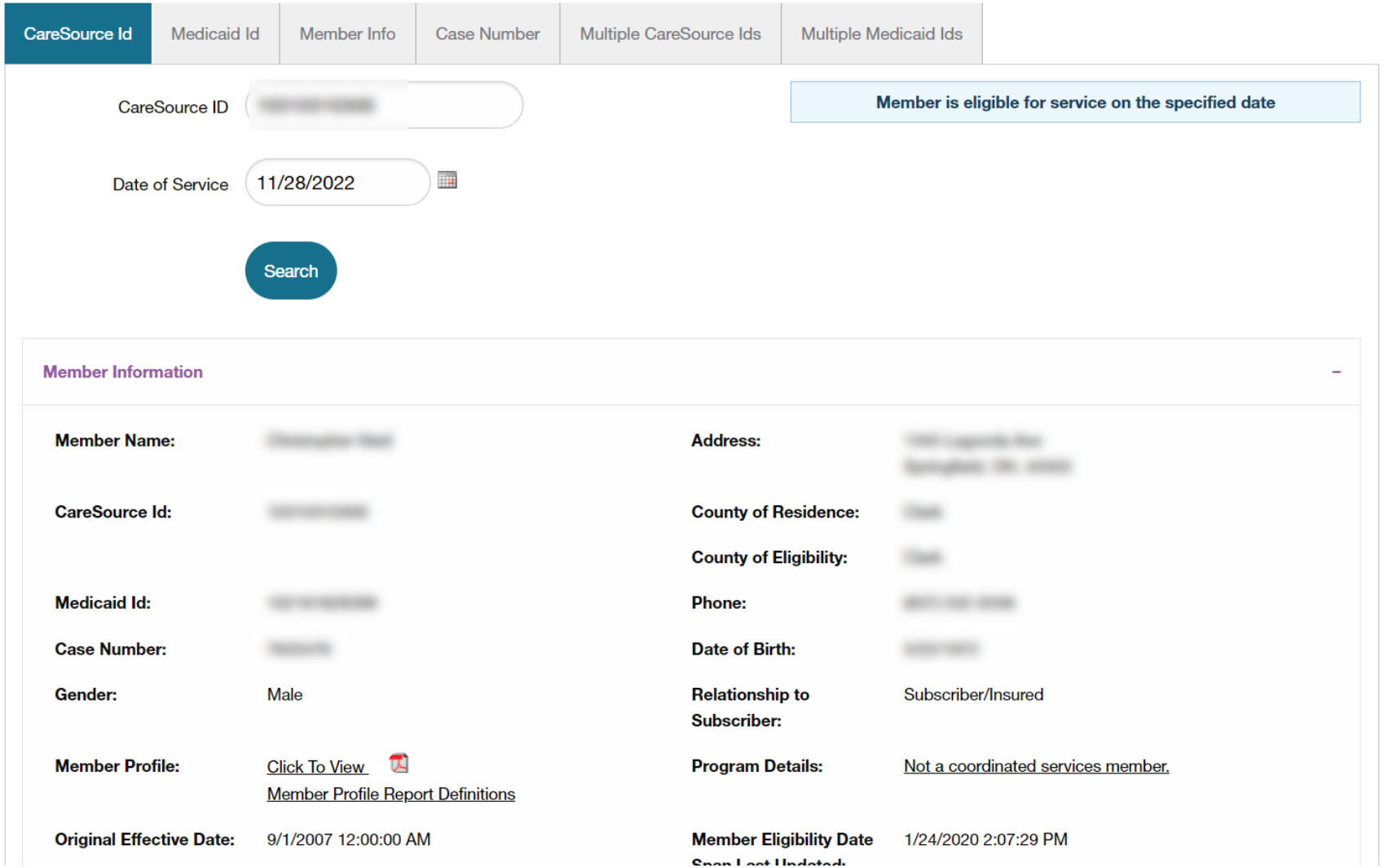
2. For added security, set up the multifactor authentication.

3. To connect your account, you will need your Provider Name, Tax ID, CareSource Provider ID and your Zip Code.

4. Review and accept the Agreement.



Member Eligibility



Member Eligibility

Program: [redacted]

Member Alerts:
1. No ambulatory or preventive care visits recorded.
2. 1-2 ER visits in 15 mos

Language Preference: English

Alternate Communication Format Needed: N/A

Special Communication Needs:

Member Aid Category: Healthy Families

Primary Care Provider (PCP): [redacted]

Phone: [redacted]

NPI #: [redacted]

Case Manager:

Case Manager Phone Number:

Subscriber Information +

Member Covered Benefits Summary +

Member Dental & Vision Services History +

EPSDT Alerts +

Upload Consent Form +

Marketplace Member ***Financial Responsibility***

ANNUAL DEDUCTIBLE, COPAYMENTS & COINSURANCE

These costs are applicable for most covered services. It is up to the provider to collect these amounts at the time of service.

BALANCE BILLING

Network providers **may not** balance bill CareSource members for covered services.

Balance billing is when a provider bills the patient for the difference between the provider's charge and the allowed amount. **For example, if the provider's typical fee is $100, and the allowed billable amount is $70, the provider may not bill the patient for the remaining $30.**

Marketplace Member *Financial Responsibility*

GRACE PERIOD

Members have a federally mandated 90-day grace period if they are receiving Advance Premium Tax Credit (APTC), or a 31-day grace period if they are not receiving APTC in which to make their payment.

- Not applicable for their initial payment
- For APTC-receiving members, 30 days after their due date CareSource will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend claims rendered
- For non-APTC members, the day after their due date, CareSource will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend any claims rendered

If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again and pended claims will be processed.

TERMINATION

After the grace period has expired, the member is terminated for non-payment of premium.

- CareSource will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- CareSource will then deny any claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.

Covered Benefits & Services

CareSource®

Covered Services

MEMBER PROGRAMS

Care Management
MyHealth®
MyStrength

BENEFITS OVERVIEW

PCP and specialist office visits
Allergy testing and treatment
Inhalation therapy
Pain management
Emergency services
Preventive services & screenings
Inpatient facility services
Outpatient facility services
Outpatient diagnostic services
Home health services
Hospice services
Durable medical equipment services
Pediatric dental services
Pediatric vision services

Covered ***Services***

ENHANCED BENEFITS

- CareSource 24 Nurse Advice Line
- Disease management education through Care Management (CM)
- Health and Wellness education
- Meal delivery (Medicare only)
- Silver & Fit (Medicare only)
- Active & Fit (Adult Dental, Vision and Fitness for Marketplace only*)

**The Adult Dental, Vision and Fitness rider allows consumers to add in coverage for some adult services under Marketplace.*

- Rehabilitation therapy services
- Habilitative services (Marketplace only)
- Family planning services
- Maternity services
- Adult dental services
- Adult vision services
- Pharmacy benefits

Services Not Covered

Medically unnecessary services
Services received from a non-network providers, with specific exceptions
Experimental or investigational services
Alternative or complimentary medicine
Cosmetic procedures
Assisted reproductive therapy
Maintenance therapy treatments
Routine dental services not provided by a DentaQuest provider
Routine vision services & eyewear not provided by an EyeMed provider
Routine hearing services & eyewear not provided by an Truhearing provider

For more details on each plan's covered services, visit **CareSource.com.**

D-SNP Transportation ***Services***

Provider Scheduling Line	833-247-RIDE, Option 1 - 7 a.m. to 7 p.m. from Monday - Friday
Standard Scheduling Timeline	Trips must be scheduled 48 hours (2 business days) up to 30 days in advance
Same Day/Sick Visit Instructions	Same-day/sick visit trips available by calling scheduling line above; provider may need to confirm urgency
60 One-Way Trips	Offered for doctor, pharmacy, gym or grocery transportation needs

Supplemental Benefits Overview

ABOUT OUR BENEFIT MANAGERS

CareSource partners with select vendors to provide expanded benefits and services, including expertise in the services and broadened networks.

These are exclusive relationships for the services considered – meaning our member must use a provider within the benefit manager's network in order for CareSource to contribute.

See **CareSource.com** for a full listing of benefits in this plan.

Marketplace Plan ***Supplemental Benefits***

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Dental (DentaQuest)	✓ All pediatric members (<19 years of age) ✓ Adults 19+ years of age on dental & vision plans	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ Explanation of Benefits (EOB)	Preventive, diagnostic, restorative, comprehensive and medical necessary orthodontics for pediatric only	1-855-453-5281
Routine Hearing (TruHearing)	✓ All Marketplace members	▪ Member Services ▪ Provider network ▪ Claims adjudication	Routine hearing exams & hearing aid discounts	1-866-202-2674
Routine Vision (EyeMed)	✓ All pediatric members (<19 years of age) ✓ Adults 19+ years of age on dental & vision plans	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ EOBs	Routine eye exam, glasses, contacts, and other value-added services	1-833-337-3129
Fitness (American Specialty Health)	✓ Adults 18+ years of age on dental & vision plans	▪ Member Services ▪ Provider network	No cost share fitness center access, home health kits, internet tools & education	1-877-771-2746

Note: You may refer your CareSource patients to these vendors using the numbers provided above.

Dual Advantage Plan ***Supplemental Benefits***

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Dental (DentaQuest)	✓ All Dual Advantage members	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ EOBs	Preventive, diagnostic, restorative, comprehensive care with annual limits of $4,000	1-855-453-5284
Routine Hearing (TruHearing)	✓ All Dual Advantage members	▪ Member Services ▪ Provider network ▪ Claims adjudication	Routine hearing exams & hearing aid fittings with two TruHearing Advanced hearing aids every 3 years	1-866-759-6826
Routine Vision (EyeMed)	✓ All Dual Advantage members	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ EOBs	Routine eye exam, glasses, contacts (with $350 allowance) and other value-added services	1-866-299-1425
Fitness (American Specialty Health)	✓ All Dual Advantage members	▪ Member Services ▪ Facility network ▪ Flex card ▪ Brain HQ	No cost share fitness center access, 1 home fitness kit, internet tools & education	1-877-427-4788

Note: You may refer your CareSource patients to these vendors using the numbers provided above.

CareSource Benefit Information

VISIT CARESOURCE.COM FOR MORE DETAILS ON:

Marketplace Plan Benefits
CareSource.com > Marketplace > Benefits & Services > Medical Benefits
Dual-Eligible Plan Benefits
CareSource.com > Dual Advantage > Benefits & Services > Medical Benefits

Prior Authorizations

CareSource®

Prior Authorization Services

Some services require prior authorization.

To use our Prior Authorization tool:

- Visit CareSource.com > Providers > Prior Authorization
- Select the proper state and plan
- Click the link to the CPT/HCPCS Prior Authorization Look-up Tool
- Select your state from the tool's drop-down
- Enter a CPT/HCPCS code into the tool

For fast authorization processing, CareSource offers **Cite AutoAuth**, an automated evidence-based system. It's quicker than phone or fax! It can be accessed on the Provider Portal.

Prior Authorization Submissions

	Marketplace	D-SNP
Online	MMMA@caresource.com Provider Portal	
Phone	**1-844-679-7865**	**1-833-230-2176**
Fax	844-417-6157	
Mail	CareSource Attn: Utilization Management P.O. Box 1307 Dayton, OH 45401-1307	

Prior Authorization Information Checklist

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member/patient name, date of birth and CareSource member ID number
- Provider name, National Provider Identifier (NPI) and Tax ID
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, treatment, or service(s) requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent, or emergency, admitting diagnosis, symptoms & plan of treatment

Note: CareSource does not require PCP referrals to see a Specialist.

You can find more information on prior authorizations in our Provider Manual, located at **CareSource.com** > Providers > Tools & Resources > Provider Manual.

Prior Authorization NIA Magellan Imaging

CareSource utilizes NIA Magellan to manage prior authorization of some outpatient radiology services.

Procedures Requiring PA through NIA	Services Not Requiring PA through NIA
• CT/CTA • MRI/MRA • PET Scan	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services
NIA Magellan Customer Service: 1-410-953-1042 | mamurphy@magellanhealth.com	

Expedited authorizations are accepted. Register at: RadMD.com.

More resources on NIA Magellan imaging may be found at **CareSource.com/Providers**.

Care Management & Quality

CareSource®

Care & Disease Management

CARE MANAGEMENT

Providers can refer patients for care management by calling **1-844-438-9498.**

- Mom and Baby Beginnings – a specialty program for pregnant moms
- Specialty NICU program for infants requiring extra care after birth

DISEASE MANAGEMENT

Members can be referred to the Care Management program to receive education on health conditions.

MEMBER EDUCATION

- MyHealth online self-management tool
- Disease-specific newsletters
- Coordination with outreach teams who provide topic-specific information
- One-to-one care management

Cultural Competency

Providers are expected to provide services in a culturally competent manner, including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic and social needs of members
- Understanding the social determinants of health that contribute to a member's health outcomes and quality of life
- Meeting the requirements of all applicable state and federal law, including contractual requirements

RESOURCES

We provide cultural competency training resources in the Provider Manual and online at **CareSource.com**. The National Culturally and Linguistically Appropriate Services (CLAS) Standards provide specific guidelines to assist you in developing a culturally competent practice.

CareSource Health Equity Commitment

At CareSource, we are dedicated to the communities in which we serve and in making a positive impact in the lives of our members. We work to eliminate health disparities, support our organization's health equity initiatives, and partner with community stakeholders to carry out this much needed work.

LIFE SERVICES

Our Life Services Department is dedicated to serving marginalized communities and to making a positive impact in the lives of diverse member populations to eliminate health disparities.

Life Services is taking an integrated approach to health equity and embedding it across CareSource. As a result, we have developed our objectives based on Pillars of Life Services:

- Workforce Development: promote long-term employment opportunities, financial literacy, connection to job training and increasing assets such as home ownership.
- Housing: increase the quality of safe and affordable housing, enhanced financial tools to develop and preserve housing units and improved affordability of housing.
- Food & Nutrition: regular and consistent access to healthy foods, education on nutrition and overall health impacts, addressing food deserts and inequalities.
- Health Equity: pursuit of health equality for black, indigenous and people of color (BIPOC), LGBTQIA, and complex populations; elimination of health disparities, partnerships with outside organizations, drive policy and advocate for change.

Multi-Language *Insert*

FOR D-SNP ONLY:

The Centers for Medicare & Medicaid Services (CMS) requires that all health plan enrollees receive the multi-language insert (MLI) document to inform beneficiaries that free interpreter services are available for the top 15 languages spoken in the United States, plus all additional languages that meet a five percent service area threshold. The MLI may be included as part of required materials or as a standalone document that includes the CareSource® brand logo.

To meet this requirement, the MLI will be included with the following materials:

- An Important Message from Medicare About Your Rights (IM)
- Detailed Notice of Discharge Form (DND)
- Medicare Outpatient Observation Notice (MOON)

Achieving Health Equity requires that our members receive health information in the language they understand. Review this document at CMS.gov/Medicare/Managed Care Marketing Documents.

For questions, please contact Provider Services at **1-844-679-7865**.

Quality Measures

HEDIS® MEASURES

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS includes a multitude of measures that look at different domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Data Systems

Wellness & Prevention

- Childhood immunizations
- Immunizations for adolescents
- Adult immunization status
- Breast cancer and cervical cancer screenings
- Colorectal cancer screening

Cardiovascular Conditions

- Controlling high blood pressure
- Comprehensive diabetes care
- Statin therapy for patients with cardiovascular disease or diabetes

Behavioral Health

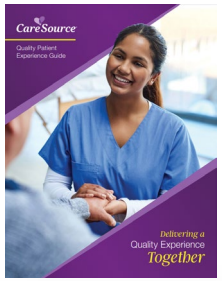
- Follow up after hospitalization for mental illness
- Antidepressant Medication Management

Access to Care

- Well child visits
- Annual dental visit
- Prenatal and postpartum care

Quality Resources

Quality Onboarding Training



Quality Patient Experience Guide

Clinical Practice Registry Training

HEDIS Coding Guides

Clinical Practice Registry Quick Tips

Clinical Practice Guideline Information

Clinical Practice Registry

The CareSource Clinical Practice Registry is an online tool available to providers to identify and prioritize needed health care services, screening, and tests for their CareSource members. It is easy to access via the secure CareSource Provider Portal.

The registry includes information on, but not limited to the following measures:

- Adult access
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Diabetes (HbA1c, eye exam, kidney/urine micro-albumin)
- Emergency room visits
- Well-care visits

Identify Gaps in Care

View preventive service history and easily identify HEDIS gaps in care to discuss during appointments

Holistically Address Patient Care

Receive alerts when CareSource members need tests or screenings, review member appointment histories and view their prescriptions

Improve Clinical Outcomes

Easily sort your CareSource members into actionable groups for population management

CareSource provides performance reports for these metrics to assist providers in enhancing practice procedures. Reports can be exported to PDF or Excel file for enhanced use.

Fraud, Waste & Abuse

Help CareSource stop fraud.

Contact us to report any suspected fraudulent activities.

Note: Providers are required to attest to completing the training after viewing.

CALL Provider Services at **1-833-230-2176** for D-SNP and **1-833-230-2101** for Marketplace
FAX 800-418-0248
EMAIL fraud@caresource.com

MAIL CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Pharmacy

CareSource®

Pharmacy Overview

PARTNERSHIP WITH EXPRESS SCRIPTS

CareSource works collectively with Express Scripts, our delegated pharmacy benefit manager (PBM), to manage our prescription drug costs and develop and implement plan-specific formulary or formularies. Contact Express Scripts at 1-800-282-2881 for any questions.

SPECIALTY DRUGS

Accredo can provide specialty medications directly to the member or the prescribing physician and coordinate nursing care, if required.

E-PRESCRIBING

CareSource formulary files are available through your electronic medical record (EMR), electronic health record (EHR), or e-prescribing vendor.

RESOURCES

- Find authorization requirements for prescriptions at **CareSource.com** > Pharmacy. Select your plan's dropdown for specific requirements.
- The Formulary search tool and prior authorization lists are available on **CareSource.com.**
- Medication Therapy Management (MTM) allows pharmacists to work collaboratively with physicians to prevent or address medication-related problems, decrease member costs and improve prescription drug adherence.

Marketplace Plan ***Pharmacy Benefits***

FORMULARY STRUCTURE

The higher the tier, the higher the cost of the drug

Tier 0	Tier 1	Tier 2	Tier 3	Tier 4
No member cost share. This tier contains preventive medications.	Contains low-cost generic drugs.	Higher coinsurance or copayment than those in Tier 1. This tier contains preferred medications that may be generic drugs or single- or multi-source brand-name drugs.	Higher coinsurance or copayment than those in Tier 2. This tier contains non-preferred medications. Includes medications considered single- or multisource brand name drugs.	Higher coinsurance or copayment than those in Tier 3. Medications generally classified as specialty medications fall into this category.

Visit **CareSource.com** > Pharmacy if you wish to access our full formulary list.

Dual Advantage Plan ***Pharmacy Benefits***

MEDICATION STRUCTURE

PHASE 1: Deductible – Members pay the full cost or applicable low-income subsidy (LIS) copay of Tiers 2, 3, 4 and 5 until they meet their deductible.
PHASE 2: Initial Coverage – Members stay in this phase until yearly drug costs reach $5,030.
PHASE 3: Coverage Gap – Members stay in this phase until yearly drug costs reach $8,000.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
	1-month supply or 3-month supply at in-network pharmacy			1-month supply at in-network pharmacy
No member cost share.	25% of total cost or appliable LIS copay.	25% of total cost or appliable LIS copay.	25% of total cost or applicable LIS copay.	25% of total cost or applicable LIS copay. Limited to 30-day supplies. Not available through mail order services.
PHASE 4: Catastrophic				
$4.15 or 5% of the total cost (whichever is greater) or applicable LIS copay.	$4.15 or 5% of the total cost (whichever is greater) or applicable LIS copay.	$10.35 or 5% of the total cost (whichever is greater) or applicable LIS copay.	$10.35 or 5% of the total cost (whichever is greater) or applicable LIS copay.	$10.35 or 5% of the total cost (whichever is greater) or applicable LIS copay.

Some prescription drugs have additional requirements. Visit **CareSource.com** > Pharmacy if you wish to access our full formulary list. Mail-order is limited to 90-day supplies.

Most members in the CareSource D-SNP plan should have LIS or “extra help”. Members can find out more about extra help and how to apply at: www.medicare.gov/basics/costs/help/drug-costs.

Provider Resources

CareSource®

Provider Resources

Visit CareSource.com to access:

- Downloadable Provider Manual
- Downloadable Provider Orientation
- Newsletters & Network Notifications
- Formularies
- Covered benefits
- Quick reference guides
- and more!

CARESOURCE PROVIDER PORTAL

https//:providerportal.caresource.com/GA

Provider Directory Information Attestation

State and federal regulations require health plans to validate and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up-to-date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

What happens if I do not attest to my information?

CMS requires health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act – in effect as of Jan. 1, 2022 – providers who do NOT attest quarterly, risk being suppressed in impacted provider directories.

Accurate provider directory information ensures we can connect the **right patients** to the **right provider**.

CareSource Contacts

	Marketplace	D-SNP
Provider Services	**1-833-230-2101**	**1-833-230-2176**
Utilization Management Fax	833-230-2176	844-417-6157
Provider Portal	https://www.caresource.com/ga/providers/provider-portal/marketplace/	https://www.caresource.com/ga/providers/provider-portal/dsnp/
Electronic Funds Transfer	ECHO Health: 1-888-485-6233	
Electronic Claims Submission	GACS1	GACS1
Claim Address	CareSource, Attn: Claims Department, P.O. Box 803, Dayton, OH, 45401-0803	
Timely Filing	180 calendar days from date of service or discharge	

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