

**CareSource® MyCare
Ohio**

2027

**Medicaid-
Only Member
Handbook**

For more information or other questions, contact us at
1-855-475-3163 (TTY: 1-833-711-4711 or 711),
Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET), and from October 1 through
March 31 we are open the same hours, seven days a week
or visit **CareSource.com/MyCare-SNP**.

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ATTENTION: To help you understand this notice, language help, interpretation services, and other aids and services are available at no cost to you. These services include oral translation, written translation, and other aids. You can request them by calling 1-855-475-3163, Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). If you have a hearing impairment may call 1-833-711-4711 or 711, Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET).

Welcome to CareSource MyCare Ohio. You are now a member of a MyCare Ohio managed care plan (MCOP). An MCOP is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports (LTSS), and other providers. It also has care coordinators and care teams to help you manage your benefits. They all work together to provide the care you need. CareSource MyCare Ohio provides health care services to eligible Ohio residents.

Who is eligible to enroll in a MyCare Ohio plan?

You were eligible to be enrolled because you met the following criteria:

- Have full Medicaid.
- Have Medicare parts A, B, and D.
- Are 21 or older.
- Are not already enrolled in a Program for All-Inclusive Care for the Elderly (PACE), a Developmental Disabilities waiver, an Intermediate Care Facility, or have other health insurance that covers both inpatient hospital stays and doctor visits.

Additionally, you have the option not to be a member of a MyCare plan if you are a member of a federally recognized Indian tribe, regardless of your age.

If you believe that you meet any of the above criteria and should not be enrolled, please contact Member Services for help.

New Member Information

This handbook tells you about your coverage under CareSource MyCare Ohio. It explains how to get healthcare services, behavioral health coverage, prescription drug coverage, and Home and Community-Based Services (HCBS) waiver services, also called long-term care services and supports (LTSS). LTSS helps you stay at home or in your community instead of going to a nursing home or hospital. It also has information like providers you can use, additional benefits, your member rights, and steps you can

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

take if you are unhappy or disagree with something.

While CareSource MyCare Ohio can provide both Medicare and Medicaid services, you chose or were assigned to get only your Medicaid services from our plan. If you want to get both your Medicare and Medicaid services from your MyCare plan, see page 43 for more information.

Network Providers

Members must get Medicaid services from facilities and/or providers in CareSource MyCare Ohio's provider network. A network provider is a provider who works with our health plan and except for pharmacy co-pays, has agreed to accept our payment as payment in full. Network providers include nursing facilities, home health agencies, medical equipment suppliers, and other providers. You may use providers outside the network only for Medicare-covered services or for Medicaid-covered services when CareSource MyCare Ohio has approved it.

MyCare plans provide transition of care benefits for services, including providers and pharmacy. For a set period of time after your enrollment in the MyCare program, you can get Medicaid services from certain out-of-network providers and/or finish receiving services ODM already approved. This is called your transition of care period. The transition period starts the first day you are effective with your MyCare plan. After the transition period, you must use providers who are part of your plan. The New Member Letter, which you receive separately after enrollment, has more information on transition time periods, services, and providers. If you are currently seeing a provider that is not in our network or if you already have services approved or scheduled, call Member Services immediately to avoid access or billing issues.

You can find which providers are in our network by calling Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET) or on our website at **CareSource.com/MyCare-SNP**. You can also contact the Ohio Medicaid Consumer Hotline at 800-324-8680, or visit www.Ohiomh.com.

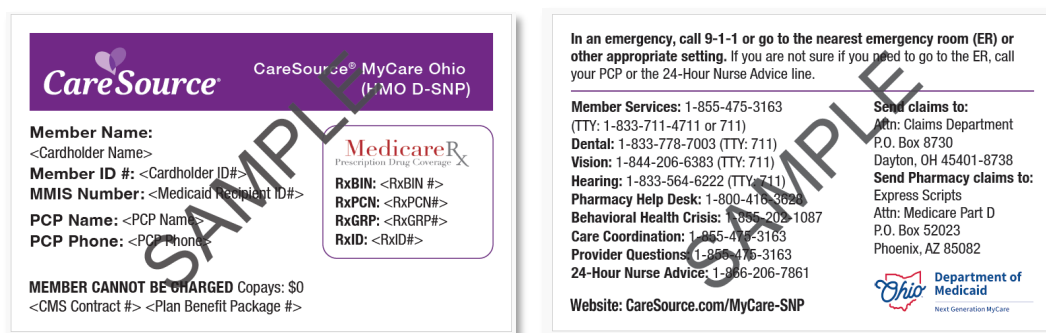
You can request a printed Provider Directory at any time by calling Member Services. Both Member Services and the website can give you the most up-to-date information about our network providers.

You can request a printed Provider Directory by calling the Member Services department or by returning the postcard you received with your new member letter and member identification (ID) card. You can also see the most up-to-date directory by using your CareSource MyLife account at MyLife.CareSource.com, or the online Find a

Doctor tool at **FindADoctor.CareSource.com**. The Provider Directory lists all our network providers as well as other non-network providers you can use to receive services. You can also visit our website at **CareSource.com/MyCare-SNP** to view up to date network provider information or call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET) for assistance.

Identification Card

Once you are enrolled, you should receive a MyCare member ID card in the mail. Each member of your family who has joined CareSource MyCare Ohio will receive their own card. These cards replace your Medicaid card. Each card is valid as long as you are a member of CareSource MyCare Ohio. This ID card will only work for Medicaid-covered services. Any medical services covered by Medicare or a selected Medicare Advantage plan will require a different ID card for those benefits. If you have a separate Medicare Part D plan, please provide your Part D ID card to your pharmacy for prescription drugs.



Always keep your ID card(s) with you

You must show your CareSource MyCare Ohio member ID card and your Medicare ID cards when you get any medical services or prescriptions for the following services:

- See your primary care provider (PCP).
- See a specialist or other provider.
- Go to an emergency room.
- Go to an urgent care facility.
- Go to a hospital for any reason.
- Go to a pharmacy.
- Go to labs or imaging providers.

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

- Go to nursing facilities.
- Receive waiver service or start with a new waiver provider.
- Get medical supplies.
- Get a prescription.
- Have medical tests.
- See a dental provider
- Get vision services

Call CareSource MyCare Ohio Member Services as soon as possible at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET) if:

- You have not received your card(s).
- Your information on the card(s) is wrong.
- Your card is damaged, lost, or stolen.
- You have a baby.

Primary Care Provider

You can keep getting Medicare services from your Medicare providers. A primary care provider (PCP) is a network provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, including your checkups and immunizations (shots), and he or she will treat you for most of your health care needs. Your PCP will be the first person you contact about your health needs and will work with you to manage your care. Your PCP will work with your care team to coordinate your health care and long-term care services. If needed, your PCP may send you to a specialist or admit you to the hospital.

Contact your PCP before you see a specialist or after you have an urgent care or emergency room visit. This allows your PCP to manage your care for the best outcomes.

Your PCP is often the best choice for managing your health care needs. They know your health history. You should see your PCP for all routine visits. Some examples of conditions that can be treated by your PCP are:

- | | | |
|---------------------------|---------------|-----------------------|
| • Dizziness | • Joint pains | • Restlessness |
| • High/low blood pressure | • Colds/flu | • Sore throat |
| | • Headache | • Removal of stitches |
| | • Earache | • Vaginal discharge |

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- Swelling of the legs and feet
- High/low blood sugar
- Persistent cough
- Loss of appetite
- Backache
- Constipation
- Rash
- Pregnancy tests
- Pain management

When You Can See a Non-Network Provider

Your primary care provider (PCP) is your personal health provider. For any routine medical needs, contact your PCP first. Members must receive Medicaid services from facilities and/or providers in the CareSource MyCare Ohio network. Exceptions include when you need emergency services and when you travel outside of our service area.

Your PCP may decide you need medical care that you can only get from a doctor or other health care provider who is not in our network. If your PCP gets prior approval from CareSource MyCare Ohio for these services, they will be covered. For other times you may see an out-of-network provider please see page 5.

Changing Your PCP

You can use CareSource MyLife to view, select or change your primary care provider (PCP). You can also search for network PCPs using **FindADoctor.CareSource.com**. If you need assistance, call Member Services.

CareSource will send you a new member ID card to let you know that your PCP has been changed. If you no longer see the PCP that is on your ID card, CareSource MyCare Ohio will send you a new ID card. Member Services can also help you schedule your first appointment, if needed.

If your PCP tells us that they are moving, retiring or leaving CareSource for any reason, we will let you know by mail within 45 days. We will assign you a new PCP or help you choose a new PCP from the CareSource network. We will also let you know if any of our network hospitals in your area are no longer in network and give you the nearest hospitals that are in the CareSource network.

Appointments

Please schedule appointments with your provider as far in advance as you can. It is important to keep your appointments. Call the provider's office at least 24 hours before you need to change or cancel a visit. If you miss too many appointments, they may ask that you choose another provider.

CareSource can provide transportation to and from the provider's office. See page 23 to learn more.

Member Services

Contact Us:

Phone: 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET)

Mailing Address: P.O. Box 8738 Dayton, OH 45401-8738

Online: **CareSource.com/MyCare-SNP**

Member Services can help you:

- Learn what services are covered and how to access these services.
- Understand any information in this handbook or in other member materials.
- Find out if a service needs prior authorization.
- Learn more about your Medicaid benefits.
- Learn more about getting both your Medicare and Medicaid-covered services from CareSource MyCare Ohio.
- Find a provider in the CareSource network.
- Change your primary care provider (PCP).
- Get a new member ID card.
- File a complaint about CareSource or a provider.
- File a complaint if you think you have been discriminated against.
- File an appeal, including an expedited appeal.
- Get an interpreter to speak to us or your providers if you speak a language other than English.
- Get materials in other formats like large print, braille or audio.

Let Member Services know if:

- ✓ Your address, phone number or email changes. You need to also change this through your County Department of Job and Family Services.
- ✓ Your designated responsible party or caregiver changes

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

- ✓ You have health insurance coverage other than Medicare.
- ✓ You are admitted to a nursing home or hospital.
- ✓ You get care in an out-of-area or out-of-network hospital or emergency room.
- ✓ You are pregnant.

Have your CareSource member ID number handy when you call. This will help us serve you faster. If you call after hours, on a weekend or holiday, you may leave a message, and we will respond within one business day. You can also reach us online at any time using your CareSource MyLife account at **MyLife.CareSource.com**. CareSource MyLife can help support many of the same functions as our Member Services team.

You can use CareSource MyLife to:

- Find network providers
- View and track prior authorizations
- View, select and change a PCP View and request a new member ID card
- File grievances and appeals
- Update contact information and designated responsible party/caregiver information

You can also reach us online through our inquiry form. Visit **secureforms.CareSource.com/en/MemberInquiry/oh**

We are closed* in 2027 on these days:

- January 1
- January 18
- May 31
- July 4
- September 6
- November 25

**Our 24-Hour Nurse Advice Line is open 24/7, 365 days a year at 1-866-206-7861 (TTY: 1-833-711-4711 or 711).*

Care Coordination

CareSource MyCare Ohio offers care coordination services to all members. When you first join our plan, you will receive a health care needs assessment within the first 15-75 days after your enrollment starts, depending on your health status. Your Care Coordinator, or a member of the Care Coordination team will contact you, to schedule a date to complete the first assessment. Your Care Coordinator or Care Coordinator delegate will complete it with you and other supports you choose. It can be done at your

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home or a location of your choice, including at a provider's office or hospital.

Our Care Coordinators are Registered Nurses, Licensed Social Workers and Licensed Independent Social Workers. They coordinate all parts of your care, including long-term care and/or waiver services if you are a resident of a long-term care facility or enrolled in a Home and Community-based Services (HCBS) waiver program. CareSource delegates Care Coordination and Waiver service coordination to the Area Agencies on Aging and we work with them to make sure your needs are met.

Working with Your Care Coordinator and Care Team

Your Care Coordinator is your main point of contact. They get to know you, your providers and specialty providers, and others who are part of your care. Your Care Coordinators can help you:

- Learn about your health and medications.
- Manage any special health conditions.
- Problem solving with billing issues.
- Get rides to health visits.
- Connect with community resources and services.
- Get support during a transition, like if you have a visit to an emergency room or a have a hospital or facility stay.

A Care Team can help you meet your goals for a healthy life by managing your health conditions. They can help you manage chronic diseases like diabetes, hypertension, heart and lung conditions, kidney disease and other health or special conditions. This team includes you, your Care Coordinator and anyone else you choose to include, like your providers, family members or caregivers. Other team members may also include:

- Legal guardians
- Authorized representatives
- External community agency staff

You can find your Care Team information in your CareSource MyLife account at **MyLife. CareSource.com.**

Everyone on the care team works together to make sure your care is coordinated. This means that they make sure tests and labs are done once, and the results are shared with the appropriate providers. It also means that your doctors should know all the medicines you take so they can reduce any negative effects. Your doctors will always have your permission before sharing your medical information with other providers.

Your Care Team may ask questions to learn more about your health. The team will give you information to help you to understand how to care for yourself and how to get services, including local resources.

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

CareSource MyCare Ohio staff, including nurses, Care Coordinator, and outreach workers will contact you as part of the Care Coordination process to ensure your needs are being met.

Get in Touch With Care Coordination

You can use your CareSource MyLife account to review your care plan, upcoming activities and appointments, prior authorization information and your medication information by logging into your account at **MyLife.CareSource.com**.

We are also happy to help if you have any questions. You can reach a care team representative 24/7. Just call 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). After hours, call 1-866-206-7861.

Our 24-Hour Nurse Advice Line can assist if you need help figuring out where to get care. Call 1-866-206-7861 (TTY: 1-833-711-4711 or 711) to reach the 24-Hour Nurse Advice Line.

Services Covered by CareSource MyCare Ohio

Medicaid helps pay medical costs for certain people with limited income and resources. The Ohio Department of Medicaid (ODM) pays for Medicare premiums for certain people, and may also pay for Medicare deductibles, co-insurance and co-payments, except for prescriptions. ODM covers LTSS such as HCBS waiver services, assisted living services, and long-term nursing home care. It also covers dental and vision services.

Because you chose or were assigned to only get Medicaid services from our plan, Medicare will be the primary payer for most services. You can choose to get both your Medicare and Medicaid benefits through CareSource MyCare Ohio. Please see page 42 for more information on how you can make this choice.

As a CareSource MyCare Ohio member, you will continue to receive all medically necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

Services covered by CareSource are listed in the covered services chart below.

Prior Authorization

Some services need to be approved by us before you can get them. **Prior authorization** is the approval that may be needed before you get a service. It must be medically necessary for your care. Your network provider will get prior authorization for the care you need. Network or in-network means that these providers see CareSource members. Services that need prior authorization are noted in the covered services chart below. You can also call Member Services to learn more. You do not need prior authorization for emergency care.

Covered Services Chart

SERVICE	MORE INFORMATION	REQUIREMENTS
Acupuncture	Acupuncture for pain management of migraine headaches and lower back pain is covered.	No prior authorization is needed.
Ambulance and wheelchair van transportation	Taking an ambulance or a wheelchair van is covered for emergencies.	Non-emergency ambulance services need prior authorization.
Behavioral health services (including mental health and substance use disorder treatment)	Mental health and substance use disorder treatment services are available through your plan. These services include: • Diagnostic evaluation and assessment • Psychological testing • Psychotherapy and counseling • Crisis intervention • Mental health services including therapeutic behavioral service, psychosocial rehabilitation,	Prior Authorization is needed for the following services: • All inpatient services • Assertive Community Treatment (ACT) for Adults • Intensive Home-Based Treatment (IHBT) • Partial Hospitalization Program (PHP) services • Substance Use Disorder (SUD) Residential: PA needed

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

SERVICE	MORE INFORMATION	REQUIREMENTS
	community psychiatric supportive treatment, assertive community treatment for adults and intensive home-based treatment for children/adolescents. • Substance use disorder treatment services including case management, peer recovery support, intensive outpatient, partial hospitalization, residential treatment, and withdrawal management. • Medication-assisted treatment for addiction. • Opioid treatment program services. • Medical services. • Behavioral health nursing services. If you need mental health and/or substance use disorder treatment services you have options. If you need help right away, call or text 988. You can self-refer to an Ohio Department of Mental Health and Addiction Services (Ohio MHAS) certified community behavioral health center or qualified behavioral health provider. You can find network providers in your provider directory or at FindADoctor.CareSource.com. You	after 30-days for the first two admissions in a calendar year and initially for a third admission in a calendar year.) • Transcranial Magnetic Stimulation (TMS)

SERVICE	MORE INFORMATION	REQUIREMENTS
	can also call Member Services to learn more. If you need help for substance use disorder treatment call the CareSource Addiction Support Line at 1-833-674-6437 (TTY: 711). Medicare also covers some of these services. Your provider may need to bill Medicare or your Medicare Advantage plan first before billing your MyCare plan.	
Certified Nurse Midwife (CNM) services	Nurses who help you with pregnancy, labor and giving birth. Find a CNM in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	No prior authorization is needed. You may self-refer for these services.
Certified Nurse Practitioner (CNP) services	Nurses who are trained in some of the medical care that doctors provide. Find a CNP in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	No prior authorization is needed. You may self-refer for these services.
Chiropractic services	Involves adjustments to the spine or other parts of the body. Find a chiropractor in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
Dental services	One dental exam and cleaning each year. Your dental benefits are covered by Delta Dental®. Find a dentist in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	These services need a prior authorization: • Some CT scans • Crowns, post and core procedures • Dentures/Partials • Oral Surgery Procedures • Periodontal Services Please check with your provider about what is needed for dental services.
Diagnostic services	Lab work, x-rays or tests done to learn more about a specific condition or disease.	These services need a prior authorization (including but not limited to): • Some bloodwork/lab testing • Scans (CT, MRI, PET)
Durable Medical Equipment (DME) and supplies	Medical equipment and supplies that can be used more than once for health services. Examples of DME are orthotics, walking aids, blood pressure machines and more. Please call Member Services to learn more. Orthotics can be replaced once each year when medically necessary. More replacements may be allowed if there is damage that cannot be repaired. This excludes repair/replacement if it was lost or stolen, misused, was broken maliciously or from gross neglect.	Prior authorization is needed for (including but not limited to): • Wheelchairs and some accessories • All rental/lease items like: CPAP/BiPAP, NPPV machines, apnea monitors, ventilators, hospital beds, specialty mattresses, high frequency chest wall oscillators, cough assist/stimulating device, pneumatic compression devices, speech generating devices and

SERVICE	MORE INFORMATION	REQUIREMENTS
		accessories, and infusion pumps • Cochlear implants including most replacements. • Left Ventricular Assist Device (LVAD) • Wound pump • Wound Vacs • Prosthetic/orthotic devices* • Oral appliances for obstructive sleep apnea • Patient transfer systems /hoyer lifts • Power wheelchair repairs • Spinal cord stimulators • Tumor treatment field therapy
Emergency services	Emergency services are covered by Medicare. If you have an emergency, call 911, or go to the nearest emergency room (ER) or other appropriate care setting. If you are not sure whether you need to go to the ER, call your PCP or the 24-Hour Nurse Advice Line at 1-866-206-7861 (TTY: 1-833-711-4711 or 711). Your PCP or the 24-Hour Nurse Advice Line can talk to you about your medical problem and give you advice on what you should do. If you need emergency services: • Go to the nearest hospital ER or other appropriate care setting. Be sure to show them	Emergency services do not need prior authorization. Call 911 or go to the nearest ER.

SERVICE	MORE INFORMATION	REQUIREMENTS
	your CareSource MyCare Ohio member ID card and your Medicare ID card. • If the provider that is treating your emergency takes care of the immediate problem but thinks that you need more care, the provider must call CareSource MyCare Ohio. • You should check in with your PCP or your Care Manager. They can check up on you and help with any follow up care you need. Learn more about follow up care on page 27. • If you are admitted to the hospital, please make sure that our plan is called within 24 hours.	
Family planning services and supplies	Family planning includes things like birth control, family planning exams, nurse midwife services, and prenatal and postnatal doctor and home visits. You can get services from your PCP or any OB/GYN or Qualified Family Planning Provider (QFPP) like Planned Parenthood. You may self-refer for these services.	Infertility diagnostic services need prior authorization.
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services	FQHCs and RHCs help people who live in rural or urban areas get care. Covered care includes office visits for primary care and specialists services, physical therapy, speech pathology and audiology services, dental services, podiatry services, vision services, chiropractic services and mental health services.	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
	Find a FQHC or RHC in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	
Free-standing birth center services	Services at a free-standing birth center are covered. Call Member Services for help finding a center or go to FindADoctor.CareSource.com .	No prior authorization is needed.
Gynecological services (OB/GYN)	OB/GYNs care for the female reproductive organs. You can get services from your PCP or any OB/GYN or family planning provider. You may self-refer for these services.	No prior authorization is needed for routine OB/GYN services.
Home health services	Home health care is a wide range of health care services that can be given in your home for an illness or injury.	Prior authorization is needed for: • Home Health aide visits • Private duty nursing (PDN) • Skilled nurse visits • Social worker visits • Occupational Therapy • Speech Therapy • Physical Therapy
Inpatient hospital services	Procedures or tests done in a hospital or medical center. They usually need an overnight stay.	All inpatient hospital services need prior authorization.
Maternity care	Prenatal and postpartum, including at-risk pregnancy services and gynecological care is covered. You can get services from your PCP or any OB/GYN or family planning provider. You may self-refer for these	Prior authorization is needed if the delivery and inpatient stay is scheduled at less than 39 weeks. It is also needed if the stay is more than 48 hours for vaginal or 96 hours for cesarean delivery.

SERVICE	MORE INFORMATION	REQUIREMENTS
	services.	
Medical nutrition supplies	Covered care includes diabetic and nutritional supplies. Diabetic supplies are limited to the following manufacturers: - Preferred test strips: Abbott/Lifescan - Preferred Continuous Glucose Monitors (CGM): Abbott Freestyle and Dexcom	Prior authorization is needed for: • Continuous glucose monitors • Donor milk • Insulin infusion device • Oral nutrition (for medical purposes) and enteral nutritional therapy.
Nursing facility/Long Term Care Services and Supports	If you need these services, please call Member Services for information on available providers. The Office of the State Long-term Care Ombudsman helps people learn about long-term care services in nursing homes, at home or in the community. They can help solve problems between providers and members or their families. They also can help you file a grievance or an appeal with our plan. For MyCare members, help with any care concern is available through the MyCare Ohio ombudsman. You can call 800-282-1206 Monday through Friday 8:00 a.m. – 5:00 p.m. Calls to this number are free. You can submit an online complaint at http://aging.Ohio.gov/contact/ or you can send a letter to: Ohio Department of Aging: MyCare Ohio Ombudsman 30 E Broad St 21st FL	Nursing facility services need prior authorization. A level of care determination is required for custodial or intermediate care.

SERVICE	MORE INFORMATION	REQUIREMENTS
	Columbus, Ohio 43215-3414	
Outpatient hospital services*	Procedures or tests that can be done in a medical center without an overnight stay.	Elective surgeries need prior authorization.
Out-of-network providers	A doctor, hospital, drugstore or other licensed provider that has not signed a contract agreeing to give services to CareSource members. CareSource will not pay for services from these providers unless it is an emergency or we have given prior authorization. Find providers in the CareSource network at FindADoctor.CareSource.com or by calling Member Services.	Prior authorization is needed for out-of-network providers or services.
Podiatry (foot) services	Services for your feet.	No prior authorization is needed.
Prescription drugs - not covered by Medicare Part D	Most of your prescription drugs are covered by Medicare Part D, but CareSource MyCare Ohio covers a few drugs that Medicare Part D does not. You can view our plan's Medicaid List of Covered Drugs on our website at CareSource.com/MyCare-SNP. You do not have any co-pays for drugs covered by our plan. We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you	Prior authorization varies by drug. Please see page 11 to learn more.

SERVICE	MORE INFORMATION	REQUIREMENTS
	can get the medication. Reasons why we may prior authorize a drug include: • There is a generic or pharmacy alternative drug available. • The drug can be misused/abused. • There are other drugs that must be tried first. • Some drugs may have quantity (amount) limits. If CareSource MyCare Ohio does not approve a prior authorization request for a medication, we will send you information on how to appeal our decision and about your right to a state hearing. You can call Member Services to ask which medications need prior authorization. You can also look on our website at CareSource.com/MyCare-SNP. Be sure to only look at the drugs on the Medicaid List of Covered Drugs to see if they require prior authorization. Our list of medications that need prior authorization can change, so you and / or your provider should check before you fill or refill a medication.	
Preventive breast cancer and cervical cancer screenings	Screenings for breast cancer (mammograms) and cervical cancer (pap tests) are covered.	No prior authorization is needed.
Preventive prostate screening	Screenings for prostate cancer for men are covered.	No prior authorization is needed.
Primary care provider (PCP) services	You will get most of your preventive care from your PCP. They will do your	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
	checkups, shots and treat you for most of your routine health care needs. Your PCP will refer you to specialists or admit you to the hospital, if needed.	
Renal dialysis (kidney disease)	Dialysis is a procedure where toxins and extra fluids are filtered out of your blood. It is a covered service.	Prior authorization is needed for dialysis.
Residential Treatment	Places where you get therapy for substance use disorder, mental illness, or other behavioral problems.	Prior authorization is needed for residential treatment.
Respite services	Care for people who are elderly or who have a disability so that their caregivers can have some time off.	Prior authorization is required for respite services.
Specialist services	A shot or immunization helps keep you from getting sick. Some shots protect you for years from diseases. Others are needed every year, like the flu shot. Work with your provider or pharmacist to get your shots at the right time.	Specialists or services outside of the CareSource network need prior authorization.
Speech and hearing services, including hearing aids	Please contact Member Services for details.	These services need a prior authorization (including but not limited to): • Speech therapy • Hearing aids
Telehealth	Telehealth means getting care through audio and / or video devices. Instead of coming into the office for your appointment, you can stay at home and use your smartphone, tablet or computer to see and talk to your medical and behavioral health providers. There is no cost for Medicaid members to use telehealth, and it can help you avoid the stress of arranging transportation.	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
	Medicaid members can use telehealth to see medical and behavioral health providers for many illnesses and injuries, common health conditions, follow-up appointments, screenings, and prescriptions. Check with your Medicare plan first to find providers who offer telehealth services.	
Tobacco cessation services	Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation are covered. Call the Ohio Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669). They are open 24 hours a day, 7 days a week including holidays. Interpreters are available if you do not speak English.	No prior authorization is needed.
Urgent care centers	Urgent Care Centers are for non-emergencies. They are for when you can't see your PCP right away. They help keep an injury, sickness or mental health issue from getting worse.	No prior authorization is required.
Vision care (optical) services, including eyeglasses	We pay for the following services: One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered.	Providers or services outside of the CareSource network need prior authorization.

SERVICE	MORE INFORMATION	REQUIREMENTS
	- 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. Deluxe frames, transitions and progressive lenses are not covered. Your vision benefits are covered by EyeMed®. Find eye care at FindADoctor.CareSource.com or by calling Member Services. Make sure the provider knows you are covered by EyeMed before you visit.	
Waiver services	The MyCare Ohio Waiver helps members receive services at home or in a home-like setting. If you are enrolled in a waiver, see your Waiver Handbook for more information.	All waiver services need prior authorization. You must be enrolled in Care Management.
Well-adult exams	A yearly well-adult exam is a checkup with a provider to go over your medical history and check your health and fitness. This is covered at one visit each year.	No prior authorization is needed.

If you must travel 30 miles or more from your home to receive covered healthcare services, CareSource MyCare Ohio will provide transportation. You can call 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET), 2 days before you need a ride to schedule a ride to and from your provider's office.

You can access transportation services through CareSource MyCare Ohio as part of your health benefit by calling Member Services.

Because you are eligible for Medicaid, you can also get help with non-emergency medical transportation (NEMT) services through your local County Department of Job and Family Services (CDJFS) for travel assistance less than 30 miles from your home. Call your CDJFS for questions or help with NEMT services.

If you are enrolled in a HCBS waiver program, you may have additional transportation benefits available to meet your needs.

Services Not Covered by CareSource MyCare Ohio

CareSource MyCare Ohio will not pay for services that are not covered by Medicaid. This includes:

- All services or supplies that are not medically necessary.
- Paternity testing.
- Services to find cause of death (autopsy) or services related to forensic studies.
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of a member.

If you have a question about whether a service is covered, call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET).

Services Not Covered by CareSource MyCare Ohio Unless Medically Necessary

CareSource MyCare Ohio will review applicable Ohio Administrative Code rules (e.g. 5160-1-61) and conduct a medical necessity review if needed. If you have a question about whether a service is covered, call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET).

CareSource MyCare Ohio will not pay for the following services that are not covered by Medicaid unless medically necessary:

- Abortions except in the case of a reported rape, incest, or to save the life of the mother.
- Biofeedback services.

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice.
- Infertility services for males or females, including reversal of voluntary sterilizations.
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered).
- Plastic or cosmetic surgery.
- Services determined by Medicare or another third-party payer.
- Sexual or marriage counseling.

Frequency Limitations

CareSource MyCare Ohio will review all requests for services from your provider. If you have a question about whether a service is covered, call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET).

Additional Benefits or Services

CareSource MyCare Ohio also offers the following extra services and/or benefits to their members. Use CareSource MyLife, your digital tool to access and manage your benefits and services, to manage your health plan on-the-go. You can use the CareSource MyLife access information and tools related to dental, vision, transportation, MyHealth and MyResources.

CareSource MyLife

CareSource MyLife lets you manage your health plan on-the-go. Use it to change and find a provider, access your member ID card, view claims and plan details and much more.

\$0 copayments for:

- ✓ Medicaid-covered drugs including prescription vitamins and mineral products and OTC products: cough suppressants, vitamins, antacids, antidiarrheals, stool softeners, laxatives wound protectants, and artificial tears. Requires a prescription from healthcare provider.
- ✓ Medicaid-covered dental services
- ✓ Medicaid-covered vision services
- ✓ nonemergency services obtained in a hospital or emergency department
- ✓

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

MyResources

MyResources helps you find low or no-cost programs in your community for food, shelter, school, work, financial support and more! Go to **CareSource.findhelp.com**. You can also call Member Services to find support near you.

MyHealth

Through MyHealth, you have access to interactive health assessments, small step guides and videos, and online tools to set and track health and wellness goals. To get started, log in to CareSource MyLife and click the *MyHealth* tab.

CareSource Life Services®

Having a good job, community support, and access to education or training opportunities impact your overall health and well-being. That's why CareSource Life Services is here for you. These resources are available to you:

- **CareSource CaregiverConnect** is designed specifically to support the caregivers who support our members through educational resources and social support.
- **CareSource FoodConnect** helps you get access to culturally and medically appropriate meals in a timely manner.
- **CareSource HousingConnect** connects you to housing supports, including resources to facilitate repairs meant to make existing housing safe.
- **CareSource PeerConnect** connects you with certified peer supporters who have similar lived experience and who can provide emotional support through life's challenges.
- **CareSource JobConnect** supports you and your key supporters in reaching your educational goals and getting a job.

Silver&Fit®: No-cost gym membership at participating locations, 1 home fitness kit per year, digital workouts, and other personalized resources.

Where to Get Care

Access care from the right provider when you need it.

 Primary Care Provider (PCP)	Used for common illnesses and advice. You will get most of your preventive care from your PCP. You should see your PCP the most often. Learn more about using a PCP on page seven.
 Telehealth	Visit with a provider by phone or computer from wherever you are. Ask your PCP if they offer telehealth.
 Convenience Care Clinics	They are found in many local drug and grocery stores. For example, you can go to clinics inside of CVS®, Kroger® and Walgreens® for basic care. Used for common illnesses like coughs, colds, sore throats and to get shots. Most clinics are open in the evening, seven days a week. Often visits can be scheduled for the same day and walk-ins are welcome.
 Urgent Care	Used to treat non-life-threatening issues like illnesses or a deep cut. Visit them when your PCP is not available, and your health issue cannot wait. They help keep an injury, sickness, or mental health issue from getting worse. Always follow up with your PCP after your visit.

 Hospital Emergency Room	Used for life-threatening issues or emergencies like chest pain or a head injury. Call 911 or go to the nearest ER. Learn more about emergency services in the <i>Covered Services Chart</i> on page 16.
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24-Hour Nurse Advice Line

Not sure where to go for care? Call our 24-Hour Nurse Advice Line.

Phone: 1-866-206-7861 (TTY: 1-833-711-4711 or 711)

Open 24 hours a day, 7 days a week, 365 days a year

The 24-Hour Nurse Advice Line can help you:

- Learn about a health problem.
- Decide when to go to your doctor, urgent care, or ER.
- Find out more about your medications.
- Find out about health tests or surgery.
- Learn about healthy eating.
- If you have a mental health crisis or concerns and need help.

Follow Up Care

You may need more care after your emergency. This is called follow up care (also called post-stabilization care). Let your care manager know that you had an emergency. They will help you with any follow-up care you need.

We will talk to the providers that give you care during your emergency. They need to if you need more care for issues that may have caused the emergency. They will ask us for approval for this care. We want you to improve.

If your emergency care came from out-of-network providers, we will work to get network providers to take over your care.

When You Travel Outside of Our Service Area

Sometimes you get sick or injured when you are traveling. Here are suggestions for what to do if this happens:

- **If it's an emergency:** Call 911 or go to the nearest emergency room
- **If it's not an emergency:** Call your PCP or the 24-Hour Nurse Advice Line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. They can help you decide what to do.
- **If you're not sure if it's an emergency:** Call your PCP or the 24-Hour Nurse Advice Line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. They can help you decide what to do.

Mental Health

Your mental health is a key part of your overall wellness, just like your physical health. That's why we offer mental health and substance use services as a core part of your benefits. Whether it's depression, anxiety, alcohol or drug dependence, we can help. Call Member Services or visit **FindADoctor.CareSource.com** to find providers. Please see *the behavioral health services* section on the covered services chart on page 12-13 to learn more.

Need Help Now?

Call 988 or text HOME to 741741 to reach a crisis counselor 24 hours a day, 7 days a week.

CareSource Behavioral Health Line

Speak to a licensed professional who has behavioral health training. Call **1-855-202-1087 (TTY: 1-833-711-4711 or 711)**. We are here for you 24/7.

CareSource Addiction Support Line

If you would like to make changes in your life like limiting alcohol use or stopping drug use, we can help. Call the CareSource Addiction Support Line at **1-833-674-6437 (TTY: 1-833-711-4711 or 711)**.

Preventive Care

Preventive care is key for the whole family. Seeing your PCP on a routine basis even if you are healthy helps your PCP find and treat problems early before they get worse. Check out the chart of recommended preventive care to get based on your age. The chart is only a guide. Some of these services may not be covered under your Medicaid-only plan. Work with your provider to get your preventive care. They will know which recommendations may be right for you based on your health history.

Recommended Preventive Care	20's	30's	40's	50's	60's and older
Yearly well-adult exam	✓	✓	✓	✓	✓
Breast cancer screening (Mammogram) – for women			✓	✓	✓
Cervical cancer screening (Pap test) – for women	✓	✓	✓	✓	✓
Chlamydia screening	✓				
Cholesterol screening	✓	✓	✓	✓	✓
Colon cancer screening			✓	✓	✓
Dental exam	✓	✓	✓	✓	✓
Diabetes screening	✓	✓	✓	✓	✓
Flu vaccine	✓	✓	✓	✓	✓
Pneumococcal vaccine					✓
Prostate cancer screening – for men				✓	✓
Shingles vaccine				✓	✓
Tetanus and diphtheria (Td) vaccine	✓	✓	✓	✓	✓
Vision exam	✓	✓	✓	✓	✓

To learn more please call Member Services or visit our website at **CareSource.com/MyCare-SNP**.

Pharmacy Services

Ask Your CareSource Pharmacist

Do you have questions about your medications? Talk to a CareSource pharmacist. They can look over your medications with you and answer questions. You do not need an appointment! Call **1-833-230-2073 (TTY: 1-833-711-4711 or 711)** to speak with a pharmacist today. We are open Monday through Friday, 8 a.m. to 5 p.m.

Medication Disposal

Do you have expired drugs or medications you no longer use? These drugs can be a health risk for toddlers, teens, or pets if they are within reach. They can also be misused. Most people who misuse prescription drugs get them from friends or family.

Drug take back sites like local pharmacies or police stations can safely get rid of these drugs for you. Visit **dea.gov** to see a list of sites near you.

CareSource has free packets that help you get rid of expired drugs or medications you no longer use. These packets are safe, easy to use, and will help reduce drug misuse. Visit **secureforms.CareSource.com/DisposeRx/** to get your free packet today.

Advance Care Planning

Get resources and help with advance care planning at no cost to you. Advanced care planning is the process of preparing for decisions about future health care events. This includes mental health care. It helps your family and providers know your wishes about your care. Some people may not want to spend months or years on life support. Others may want all steps taken to live longer.

You will need to answer some tough questions when you make an advance directive. Think about these things when you make yours:

- It is a choice to write one.
- The law states that you can make choices about health care and surgical treatment, such as agreeing to or refusing care.
- Having one does not mean you want your life to end.
- You can choose a person to make health care choices for you when you cannot make them. You may also use it to keep certain people from making decisions for you.
- You must be of sound mind to make one.

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

- You must be at least 18 years old or an emancipated minor to have one.
- Having one will not change other insurance.
- They can be changed or ended at any time.

Advance directives should be kept in a safe place. Copies should be given to your family, health care agent and providers.

Talking about advance care planning is your choice. To get these services, call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**. Learn more at **CareSource.com/MyCare-SNP**.

Member Rights

As a member of our plan, you have the following rights:

- To receive all services that our plan must provide.
- To be treated with respect, dignity and privacy.
- To have your medical records kept private.
- To take part in decisions about your health care with your providers.
- To get information about your health. This information may also be shared with someone you have legally approved or your emergency contact when it is not in your best interest to receive the information directly.
- To get information about your health care in a way you can understand.
- To have privacy during medical care so others cannot hear or see you.
- To be free from any form of restraint or seclusion used as a way to force, discipline, or retaliate, as specified in federal rules.
- To request and receive a copy of your medical records and to ask for a change or correction if needed.
- To say yes or no to sharing information about you unless required by law.
- To say no to treatment or therapy. If you say no, the provider or our plan must talk to you about what may happen and must note it in your medical record.
- To file an appeal, a grievance, or state hearing. See page 37 of this handbook for more information.
- To get written member information from our plan:
 - At no cost to you.
 - In the most common non-English languages of members.
 - In other formats for members who may need extra help understanding it.
- To get free help from our plan if you do not speak English or need help understanding the information.
- To get free help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to refuse care from that

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

person.

- To be told of any experimental research and to refuse to take part.
- To make advance directives, also called a living will. See page 29 for more information.
- To file a complaint with ODM if your advance directive is not followed.
- To use your rights freely, knowing that your plan, its providers, or ODM will not treat you differently because of it.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- To change your PCP no more than once a month.
- If you are a female, to see a women's health provider in our network for Medicaid-covered women's health services.
- To get a second opinion for Medicaid-covered services from a qualified provider in our network. If no qualified provider is available, we must arrange a visit with a provider not in our network at no cost to you.
- To get information about CareSource MyCare Ohio from us.
- To contact the ODM and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

**The Ohio Department of Medicaid
Office of Human Resources, Employee Relations**

P.O. Box 182709
Columbus, Ohio 43218-2709

E-mail: ODM_EEO_employeerelations@Medicaid.Ohio.gov
Fax: (614)644-1434

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

Refer to the [Ohio Administrative Code Rule 5160-26-08.3](#) for more information about Member Rights.

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

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

about how we protect your personal health information, see our privacy practices on page 33.

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. 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.

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,

- payment(s),
- 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. We will do this 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. Use 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. You can send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

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. We may share it 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

Consent to Share Health Information

CareSource shares your health information, including Sensitive Health Information (SHI). SHI can be information related to drug and/or alcohol treatment, genetic testing results, HIV/AIDS, mental health, sexually transmitted diseases (STD), or communicable/other diseases that are a danger to your health. This information is shared to handle your care and treatment or to help with benefits. This information is shared with your past, current, and future treating providers. It is also shared with Health Information Exchanges (HIE). An HIE lets providers view information that CareSource has about members. You have the right to tell CareSource you do not want your health information (including SHI) shared. If you do not agree to share your health information, it will not be shared with providers to handle your care and treatment or to help with benefits. It will be shared with the provider who treats you for the specific SHI. If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as they could if you did approve sharing.

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: We may arrange more care for you based on information sent to us by your doctor.

Run our organization. We can use and give out your information to run our company. We use it to contact you when needed. We are not allowed to use genetic

information to decide whether we will give you coverage. We cannot use it to decide the price of that coverage.

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.

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.

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.

To respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

To work with a medical examiner or funeral director. 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, or in response to a court order.

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

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.
 - 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. We are required 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 June 18, 2018. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice. The new one would apply to all health information we keep. If this happens, the new notice will be available upon request. It will also be posted on our web site. You can 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: HIPAAPrivacyTeam@caresource.com

Phone: 1-855-475-3163, ext. 12023 (TTY: 1-833-711-4711 or 711)
We are open 8 a.m. – 8 p.m. Monday through Friday.

Appeals and Grievances

Appeals and grievances are ways to let CareSource MyCare Ohio know if you are unhappy or do not agree with a decision we made.

If you are unhappy with anything about our plan or its providers, you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you authorize to speak for you, can contact us. If you want someone to speak for you, you will need to let us know. CareSource MyCare Ohio wants you to contact us so we can help you.

To contact us, you can:

- Call the Member Services department at 1-855-475-3163 (TTY: 1-833-711-4711 or 711).
- Fill out the form in your member handbook on page 48.
- Call the Member Services department to request they mail you a form.
- Visit our website at **CareSource.com/MyCare-SNP or MyLife.CareSource.com**.
- 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 Medicaid-only member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

CareSource
Attn: Member Grievances & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

CareSource MyCare Ohio will send you something in writing if we:

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

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

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

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

If you do not agree with the decision or action written in the letter, and you contact us within 60 calendar days of receiving it and ask us to change our decision. **This is called an appeal.** The 60-calendar day period starts the day after the letter is mailed. If we decide to reduce, suspend or stop services before you receive all approved services, your letter will explain how you can keep getting services if you choose and when you may have to pay for them.

Unless we tell you a different date, we must give you a written answer to your appeal within 15 calendar days after you contact us. If we do not change our decision, we will tell you how to request a state hearing. You may only request a state hearing after you have gone through the CareSource MyCare Ohio appeal process.

If you contact us because you are unhappy with something about CareSource MyCare Ohio or one of our providers, **this is called a grievance.** CareSource MyCare Ohio will give you an answer to your grievance by phone, or by mail if we cannot reach you by phone, within these time frames:

- Two working days for grievances about not being able to get medical care.
- 30 calendar days for all other grievances.

If we need more time to make a decision on your appeal or a grievance, we will send you a letter saying that we need up to 14 more calendar days. The letter will also explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

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

**Ohio Department of Medicaid
Bureau of Managed Care Compliance
and Oversight**
P.O. Box 182709
Columbus, Ohio 43218-2709

800-605-3040 or 800-324-8680
TTY: 800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor– Suite 300
Columbus, Ohio 43215

800-686-1526

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833- 42 711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **CareSource.com/MyCare-SNP** or **CareSource.MyLife.com**

State Hearings

A state hearing is a meeting with you or your authorized representative, someone from the CDJFS, someone from CareSource MyCare Ohio, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think CareSource MyCare Ohio did not make the right decision, and CareSource MyCare Ohio will explain the reasons for making our decision. The hearing officer will listen and then make a decision based on the rules and the information given by you and CareSource MyCare Ohio.

CareSource MyCare Ohio will notify you of your right to request a state hearing if we do not change our decision or action as a result of your appeal.

If you want a state hearing, you or your authorized representative must request a hearing within 90 calendar days. The 90 calendar day period starts the day after the letter is mailed. If we decide to reduce, suspend or stop services before you receive all approved services, your letter will explain how you can keep getting services if you choose and when you may have to pay for them.

You may only request a state hearing after you have gone through the CareSource MyCare Ohio appeal process.

To request a hearing, you can:

- Sign and return the state hearing form to the address or fax number listed on the form.
- Call the Bureau of State Hearings at 866-635-3748.
- Submit your request online at https://hearings.jfs.Ohio.gov/apps/share/#_frmlogin.
- Submit your request via e-mail at bsh@jfs.Ohio.gov.

If you want information on free legal services but do not know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 800-589-8889.

State hearing decisions are usually made within 70 calendar days after the request is received. However, if the CareSource MyCare Ohio or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be made as quickly possible but no later than three working days after the request is received. Expedited decisions are for cases where the standard time frame

could seriously harm your life, health or ability to attain, maintain, or regain maximum function.

Accidental Injury or Illness (Subrogation)

If you need care for an injury or illness that was caused by another person or business, you must call Member Services to let us know. For example, this could include a car crash, a dog bite, or a fall in a store. Another insurance company may have to pay the doctor and/or hospital bill. When you call, be ready to share the name of the person at fault, their insurance company, and the name(s) of any attorney(s) involved.

Other Health Insurance (Coordination of Benefits)

We know you may also have coverage through Medicare. If you have any other health insurance or lost the health insurance you had previously reported, call Member Services and your county caseworker right away. If you do not share this information, it can cause problems with getting care or paying medical bills.

Loss of Insurance Notice (Certificate of Creditable Coverage)

Anytime you lose health insurance you should receive a notice, known as a certificate of creditable coverage, from the insurance company that says you no longer have insurance. Keep a copy of this notice for your records in case you are asked to show it.

Loss of Medicaid Eligibility

It is important that you keep your appointments with the CDJFS. If you miss a visit or do not give them the information they ask for, you can lose your Medicaid eligibility. If this happens, our plan will be told to end your membership as a Medicaid member, and you will no longer be covered.

Automatic Renewal of MyCare Ohio Membership

If you lose your Medicaid eligibility but it starts again within 90 days, you will automatically be re-enrolled in CareSource MyCare Ohio.

Ending Your MyCare Ohio Membership

Since you are eligible for the MyCare Ohio program, you must select a MyCare Ohio plan unless you meet one of the exceptions listed on page 39.

If you only get your Medicaid benefits through your MyCare plan and want to pick a different plan for your Medicaid benefits, you can pick a different plan for up to 90 days after you joined the program. You may also change plans during the annual open enrollment period.

Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you choose another MyCare plan, your new plan will send you information in the mail before your membership start date.

Contact the Ohio Medicaid Consumer Hotline at 800-324-8680 to discuss your options for picking a new plan.

Choosing a New MyCare Ohio Plan

If you are thinking about switching MyCare plans and want to keep seeing your current Medicaid providers, you should learn about your options first. Each plan has its own provider network and written information about benefits and the rules you must follow. If you want written information about a plan, or if you have questions, you can call the plan or the Ohio Consumer Medicaid Hotline at 800-324-8680. TTY users should call Ohio relay at 7-1-1. You can also find information about the plans at www.ohiomh.com by clicking the “Compare Next Generation MyCare Plans” button under “Compare Plans and Find a Provider” section.

Choosing to Receive Both Your Medicare and Medicaid Benefits from a MyCare Ohio Plan

If you want to align your Medicare and Medicaid benefits through a MyCare plan, you

can enroll at any time through Medicare. Your new plan and benefits will begin on the first day of the following month. Contact Medicare at 800-633-4227 or the Ohio Medicaid Consumer Hotline at 800-324-8680 to discuss your options for getting your benefits through one plan. TTY users should call Ohio relay at 7-1-1.

Currently, only your medically necessary Medicaid-covered services are available through CareSource MyCare Ohio. You can choose CareSource for your Medicare benefits too. When you choose CareSource MyCare Ohio (HMO D-SNP) for both your Medicare and Medicaid benefits, you will also get these additional benefits:

- The Healthy Benefits+ debit card which provides members \$300 per month to purchase over-the-counter (OTC) items plus dental, vision and hearing services and accessories at eligible providers who accept the card. For members approved for Special Supplemental Benefits for the Chronically Ill (SSBCI), members may use the Healthy Benefits+ card for qualifying items and services such as: healthy food*, utilities*, rent/mortgage assistance* and more*!
- \$595 each year with My CareSource Rewards® program, which offers members incentives for completing wellness activities**
- \$0 Medicare- & Medicaid-covered drugs.
- Enhanced dental, vision and hearing benefits.
- Unlimited transportation to health-related locations including appointments with your primary care provider (PCP), pharmacies, gyms, grocery stores, and community/wellness services. For the full list of \$0 CareSource MyCare Ohio benefits call 1-855-475-3163 (TTY: 1-833-711-4711 or 711) or visit our website at [CareSource.com/MyCare-SNP](https://www.CareSource.com/MyCare-SNP).
- Silver&Fit®: No-cost gym membership at participating locations, 1 home fitness kit per year, digital workouts, and other personalized resources.

Just Cause Membership Terminations

You can also change plans throughout the year for just cause. Just cause is when you are concerned with or have issues getting care due to the plan you are on. Before you can ask for just cause, you must first call your MyCare Ohio plan and give them a chance to resolve the issue. Requesting just cause will not return you to the Medicaid fee-for-service (FFS) program, but it may allow you to choose a plan outside of the open enrollment period. If your plan cannot resolve the issue, you can ask for just cause at any time if you have one of the following reasons:

1. Your plan does not cover a medical service that you need because of moral or religious objections.

If you have questions, please call Member Services at 1-855-475-3163 (TTY: 1-833-711-4711 or 711), Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). For more information, visit **[CareSource.com/MyCare-SNP](https://www.CareSource.com/MyCare-SNP)** or **[CareSource.MyLife.com](https://www.CareSource.MyLife.com)**

2. Your doctor has said that some of the medical services you need must happen at the same time, and not all of those services are available through your plan's network providers.
3. You have concerns that you are not getting quality care, and the services you need are not available from another network provider through your plan.
4. You cannot get medically necessary Medicaid-covered services, or you cannot find providers who know how to meet your special health care needs.
5. The PCP that you chose is no longer a network provider through your plan, and they were the only network PCP who spoke your language and was located within a reasonable distance from you, and another plan has a PCP in its network who speaks your language that is located within a reasonable distance from you and will accept you as a patient.
6. Other - if you think staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to change your membership for just cause by calling the Ohio Consumer Medicaid Hotline at 800-324-8680. TTY users should call Ohio relay at 7-1-1. ODM will review your request to change your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if ODM will change your membership and the date it changes. If your just cause request is denied, ODM will send you information that explains your state hearing right for appealing the decision.

Things to keep in mind if you end your membership:

- If you have already taken steps to end your membership, keep using CareSource MyCare Ohio providers until the day your new MyCare plan starts, unless you are still in your transition period. If you chose a new plan and have not received a member ID card before the first day of the month your coverage starts, call the plan's Member Services department. If they are unable to help you, call the Ohio Consumer Medicaid Hotline at 800-324-8680. TTY users should call Ohio relay at 7-1-1.
- If you have chosen a new MyCare plan and have Medicaid services scheduled, call your new plan to be sure your providers are in its network and any required paperwork is complete. For example, you should call your new plan for home health, private duty nursing, mental health, substance use disorder, dental, vision and waiver services.

Can CareSource MyCare Ohio End My Membership?

CareSource MyCare Ohio may ask ODM to end your membership for certain reasons. ODM must approve the request before your membership can be ended. We may ask to

end your membership if:

- You commit fraud or misuse your member ID card.
- Your behavior is disruptive or uncooperative and it affects our ability to provide services to you or other members.

CareSource MyCare Ohio provides services to our members because of a contract we have with ODM. If you want to contact ODM, you can call or write to:

**Ohio Department of Medicaid
Bureau of Managed Care**

P.O. Box 182709

Columbus, Ohio 43218-2709

800-324-8680 (Monday through Friday 7 a.m. - 8 p.m. and Saturday 8 a.m. - 5 p.m.)

TTY users should call Ohio Relay at 7-1-1

You can also visit the ODM on the web <https://medicaid.ohio.gov/home>.

You may also contact your local CDJFS if you have questions or need to change your address or income or other insurance.

You can contact CareSource MyCare Ohio if you want more information about our plan, how it is organized, or how we pay our providers. You can also call if you have suggestions for improvements. Please call the Member Services department at 1-855-475-3163 (TTY: 1-833-711-4711 or 711).

MANAGED CARE TERMINOLOGY

Appeal: a member's request for the CareSource MyCare Ohio to review an adverse benefit determination.

Co-Payment: a fixed amount a member pays for a covered health care service.

Durable Medical Equipment: equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the home.

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the

health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Medical Transportation: transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

Emergency Room Care: medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency Services: covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with the [MCOP].

Excluded Services: health services that the CareSource MyCare Ohio does not pay for or cover.

Grievance: a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

Habilitation Services and Devices: services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Health Insurance: A contract that requires CareSource MyCare Ohio to pay some or all of your health care costs in exchange for a premium.

Home Health Care: services that include home health nursing, home health aide services and skilled therapies.

Hospice Services: a public agency, a private organization, or a subdivision of either,

subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals. (OAC rule 5160-56-01(V)).

Hospitalization: care in a hospital that requires admission as an inpatient.

Hospital Outpatient Care: diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital.

Medically Necessary: criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Network: the CareSource MyCare Ohio's contracted providers available to the CareSource MyCare Ohio's members.

Non-Participating Provider: any provider with an ODM provider agreement who does not contract with an [MCOP] but delivers health care services to an CareSource MyCare Ohio's members.

Participating Provider: any provider, group of providers, or entity that has a network provider contract with the CareSource MyCare Ohio in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the CareSource MyCare Ohio's provider agreement or contract with ODM.

Physician Services: "Practitioner of physician services": are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners or physician assistants. (OAC rule 5160-2-02(L)).

Plan: "Managed care organization (MCOP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. (OAC rule 5160-26-01(X)).

Post-stabilization care services: covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or

under the circumstances described in 42 C.F.R.422.113 to improve or resolve the member's condition.

Preauthorization: a decision by the CareSource MyCare Ohio that a health care service, treatment plan, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Premium: "Premium" means the monthly payment amount per member to which the CareSource MyCare Ohio is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM. (OAC rule 5160-26-01(NN)).

Prescription Drugs: simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Primary Care Physician or Provider: an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Ohio Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Ohio Administrative Code contracting with an CareSource MyCare Ohio to provide services as specified in rule 5160-26-03.1 of the Ohio Administrative Code.

Provider: a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to an CareSource MyCare Ohio's members.

Rehabilitation Services and Devices: specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

Skilled Nursing Care: specific tasks that must, in accordance with Chapter 4723. of the Ohio Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

Specialist: A physician specialist focused on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Complete Sections I and II of the form entirely, describe the issue(s) in as much detail as possible, and submit it to CareSource. To ensure a decision can be made by CareSource, the following documentation should be submitted with this form:

- | Section I – Member Information | |
|---|---|
| Member Name: | Date of Birth (MM/DD/YYYY): |
| Member ID Number: | Member Phone Number: |
| Member Address: | |
| Date of Request (MM/DD/YYYY): | Request Type:
☐ Grievance/Complaint ☐ Appeal |
| Section II – Description of Specific Issue | |
| Please state all details relating to your request including names, dates and places. Attach another sheet of paper to this form if more space is needed. | |
| | |
| By signing below, you agree that the information provided is true and correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf. | |
| Member Signature: | Date of Request (MM/DD/YYYY): |
| Member's Authorized Representative Name (if applicable): | Authorized Representative Signature (if applicable): |

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Non-Discrimination Notice

We follow all state and federal civil rights laws. We do not discriminate, exclude, or treat people differently based on race, color, national origin, disability, age, religion, sex (which includes pregnancy, gender, gender identity, sexual preference, and sexual orientation), or based on marital, health, or public assistance status. We want all people to have a fair and just chance to be as healthy as they can be.

We offer free aids, services, and reasonable modifications if you have a disability. We can get a sign language interpreter. This helps you talk with us or to your providers. Get your printed materials in large print, audio, or braille at no cost. We can also help if you speak a language other than English. We can get an interpreter who speaks your language. Or get printed materials in your language. You can get this all at no cost to you. Call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)** if you need any of this help. We are open Monday through Friday, 8 a.m. to 8 p.m., Eastern Time (ET). We are here for you.

You may file a grievance if we did not provide these services to you or if you think we discriminated in any other way.

Mail: CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947
Dayton, OH 45401
Phone: 1-844-539-1732 (TTY: 711)
Fax: 1-844-417-6254
Email: CivilRightsCoordinator@CareSource.com

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Mail: U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Mail the complaint form found at
www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
Phone: **1-800-368-1019 (TTY: 1-800-537-7697)**
Online: ocrportal.hhs.gov

You can find this notice at **CareSource.com**.



Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call 1-855-475-3163 (TTY: 1-833-711-4711 or 711).

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad. Llame al 1-855-475-3163 (TTY: 1-833-711-4711 o 711).

Отримайте безкоштовну допомогу своєю мовою з перекладачами та іншими письмовими матеріалами. Отримайте безкоштовні засоби допомоги та підтримку, якщо Ви є особою з інвалідністю. Телефонуйте за номером 1-855-475-3163 (TTY: 1-833-711-4711 або 711).

Jwenn èd gratis nan lang ou ak entèprèt ak lòt materyèl ki ekri. Jwenn èd ak sipò gratis si ou gen yon andikap. Rele 1-855-475-3163 (TTY: 1-833-711-4711 oubyen 711).

तपाईंकै भाषामा दोभाषे तथा अन्य लिखित सामग्रीहरू निःशुल्क प्राप्त गर्नुहोस्। तपाईंसँग असक्षमता छ भने निःशुल्क सहायताहरू तथा समर्थन प्राप्त गर्नुहोस्। 1-855-475-3163 (TTY: 1-833-711-4711 वा 711) मा फोन गर्नुहोस्

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. احصل على مساعدات مجانية ودعم مجاني إذا كنت تعاني من إعاقة. اتصل على الرقم (711 أو 1-833-711-4711) 1-855-475-3163 (TTY: 1-833-711-4711 أو 711)

Получите бесплатную помощь на своём языке с переводчиками и другими письменными материалами. Получите бесплатные вспомогательные средства и поддержку, если Вы являетесь лицом с инвалидностью. Звоните по номеру 1-855-475-3163 (TTY: 1-833-711-4711 или 711).

Ka hel caawimo bilaash ah luqadaada leh turjubaano iyo agab kale oo qoran. Hel gargaar iyo taageero bilaash ah haddii aad naafo tahay Wac 1-855-475-3163 (TTY: 1-833-711-4711 ama 711).

Obtenez gratuitement de l'aide dans votre langue au moyen d'interprètes et de documentation écrite. Obtenez des aides et un soutien gratuits si vous avez un handicap. Appelez le 1-855-475-3163 (ATS: 1-833-711-4711 ou 711).

Habwa ubufasha mu rurimi rwawe kubantu ubifashijwemo n'abasemuzi hamwe n'inyandiko. Habwa ubufasha n'inkunga ku buntu nimba ufite ubumuga. Call 1-855-475-3163 (TTY: 1-833-711-4711 cyangwa 711).

Pata msaada wa bure katika lugha yako pamoja na wakalimani na maandishi mengine. Pata usaidizi na msaada bila malipo kama una ulemavu. Piga simu 1-855-475-3163 (TTY: 1-833-711-4711 au 711).

Og'zaki tarjimonlar va boshqa yozma materiallar orqali o'z ona tilingizda bepul yordam oling. Agar nogironligingiz bo'lsa, bepul yordam va ko'mak oling. 1-855-475-3163 (TTY: 1-833-711-4711 yoki 711) raqamiga qo'ng'iroq qiling.

د شفاهي ژباړونکو او نورو لیکل شویو موادو له لارې په خپله ژبه کې وړیا مرسته ترلاسه کړئ. وړیا مرستې او ملاتړ ترلاسه کړئ که تاسو معلومات لرئ. (711 یا TTY: 1-833-711-4711 1-855-475-3163 ته زنگ ووهئ).

Tercüman desteği ve diğer yazılı materyallerden yararlanarak kendi dilinizde ücretsiz yardım alın. Engeliniz varsa ücretsiz yardım ve destek alın. Destek Hattımız: 1-855-475-3163 (TTY: 1-833-711-4711 veya 711).

برای دریافت کمک رایگان به زبان خود با مترجمان و دیگر مواد کتبی تماس بگیرید. برای دریافت کمک‌ها و حمایت رایگان در صورت داشتن معلولیت اقدام کنید. به این شماره‌ها تماس بگیرید (711 یا TTY: 1-833-711-4711 1-855-475-3163).

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị qua thông dịch viên và các tài liệu dạng văn bản khác. Nhận hỗ trợ và trợ giúp miễn phí nếu quý vị là người khuyết tật. Gọi số 1-855-475-3163 (TTY: 1-833-711-4711 hoặc 711).

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