**CareSource®**
**MyCare Ohio**
(Medicare-Medicaid Plan)

# 2024 Member Handbook

CareSource®

# CareSource® MyCare Ohio *Member Handbook*

**January 1, 2024 – December 31, 2024**

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

## *Member Handbook* Introduction

This handbook tells you about your coverage under CareSource MyCare Ohio through December 31, 2024. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community-based waiver services (also called long-term services and supports). Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

**This is an important legal document. Please keep it in a safe place.**

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

ATTENTION: If you speak Spanish, language services, free of charge, are available to you. Call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. The call is free.

ATENCIÓN: Si habla espanol, tiene disponible los servicios de asistencia de idioma gratis. Llame al **1-855-475-3163 (TTY: 1-833-711-4711 o 711)**, 8 a.m. a 8 p.m., el lunes a viernes. La llamada es gratis.

You can get this document for free in other formats, such as large print, braille, or audio. Call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. The call is free.

If you have any problems reading or understanding this handbook or any other CareSource MyCare Ohio information, please contact Member Services. We can explain the information or provide the information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

To receive this document in a language other than English or in an alternate format, please contact Member Services. We will keep a record of that request. For help or if you need to change your request, call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. This call is free.

## Table of Contents



## Disclaimers

- We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Someone who speaks Spanish can help you. This is a free service.
- CareSource® MyCare Ohio (Medicare-Medicaid) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.
- Coverage under CareSource MyCare Ohio is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- You may have to pay for some services, and you need to follow certain rules to have CareSource MyCare Ohio pay for your services.

MyCareOhio
Connecting Medicare + Medicaid

# Chapter 1: Getting started as a member

## Introduction

This chapter includes information about CareSource MyCare Ohio, a health plan that covers all your Medicare and Medicaid services. It also tells you what to expect as a member and what other information you will get from CareSource MyCare Ohio. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

## A. Welcome to CareSource MyCare Ohio

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

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

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

CareSource is a nonprofit organization that has been meeting the needs of health care consumers for over 33 years. We are a community-based health plan that understands diverse needs and serves more than 1.5 million members in the state of Ohio. The CareSource approach to our members is founded on strong community partnerships and a geographic focus. We believe in a person-centered approach to care management in order to build lasting relationships that transform lives.

## B. Information about Medicare and Medicaid

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

### B1. Medicare

Medicare is the federal health insurance program for:

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

### B2. Medicaid

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

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

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

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

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

## C. Advantages of this plan

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

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

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a Care Manager. This is a person who works with you, with CareSource MyCare Ohio, and with your care providers to make sure you get the care you need. They will be a member of your care team.
- You will be able to direct your own care with help from your care team and Care Manager.

- The care team and Care Manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
    - Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
    - Your care team will make sure your test results are shared with all your doctors and other providers.

## D. CareSource MyCare Ohio's service area

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

Our service area includes these counties in Ohio: Columbiana, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit, Trumbull, and Wayne

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state. Refer to Chapter 8, Section J, *Your responsibilities as a member of the plan* for more information about the effects of moving out of our service area.

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

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

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it); **and**
- you have Medicare Parts A, B and D; **and**
- you have full Medicaid coverage; **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are 18 years of age or older at time of enrollment.

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

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

Additionally, you have the choice to disenroll from CareSource MyCare Ohio if you are a member of a federally recognized Indian tribe.

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

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

When you first join the plan**,** you will get a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. You will receive a letter telling you who your Care Manager is. Your Care Manager or a member of the Care Management Team will contact you to schedule your first assessment. The health care assessment will be completed with you, your family, caregivers, Care Manager, and other support people you want to include. It can be done at your home or a location of your choice, including a physician's office or over the phone after a hospital stay. An in-home assessment is required for some members.

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

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

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

## G. Your care plan

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

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

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

## H. CareSource MyCare Ohio monthly plan premium

CareSource MyCare Ohio does not have a monthly plan premium.

## I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9, Section D, *Coverage decisions and appeals*. You can also call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or Medicare at 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You can also refer to the *Member Handbook* at **CareSource.com/MyCare** or download it from this website.

The contract is in effect for months in which you are enrolled in CareSource MyCare Ohio between January 1, 2024 and December 31, 2024.

## J. Other important information you will get from us

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

### J1. Your CareSource MyCare Ohio Member ID Card

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


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

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

card instead of your CareSource MyCare Ohio Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A, *Asking us to pay for your services or drugs* to find out what to do if you get a bill from a provider.

### J2. New Member Letter

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

### J3. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the CareSource MyCare Ohio network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan (refer to page 9) and for certain services (refer to Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers*).

You can ask for a printed *Provider and Pharmacy Directory* (electronically or in hard copy form) at any time by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at **CareSource.com/MyCare** or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

**Definition of network providers**

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

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

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Network providers should not bill you directly for services covered by the plan. For information about bills from network providers, refer to Chapter 7, Section A, *Asking us to pay for your services or drugs*.

**Definition of network pharmacies**

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

### J4. *List of Covered Drugs*

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

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

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, you can visit the plan's website at **CareSource.com/MyCare** or call Member Services **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

### J5. List of Durable Medical Equipment (DME)

With this *Member Handbook*, we sent you CareSource MyCare Ohio's List of Durable Medical Equipment. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at **CareSource.com/MyCare**. Refer to Chapter 4, Section D, *The Benefits Chart* to learn more about DME.

If you are new to CareSource MyCare Ohio and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. If you disagree with your doctor, you can ask them to refer you for a second opinion.

### J6. *Member Handbook* Supplement or "Waiver Handbook"

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

### J7. The *Explanation of Benefits*

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

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

An EOB is also available when you ask for one. To get a copy, contact Member Services.

## K. How to keep your membership record up to date

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

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

Let us know the following:

- changes to your name, your address, or your phone number
- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- admission to a nursing home or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so).

- if you have to use a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call, we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

To update your personal information online, go to **MyCareSource.com** or **CareSource.com/MyCare** and click on *Members*. Then click on My CareSource® to open an online account.

## K1. Privacy of your personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section D, *Our responsibility to protect your personal health information (PHI)*.

# Chapter 2: Important phone numbers and resources

## Introduction

This chapter gives you contact information for important resources that can help you answer your questions about CareSource MyCare Ohio, the State of Ohio, Medicare, and your health care benefits. You can also use this chapter to get information about how to contact your Care Manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

## A. How to contact CareSource MyCare Ohio Member Services

| | |
|---|---|
| **CALL** | **1-855-475-3163** This call is free.<br>8 a.m. – 8 p.m., Monday – Friday<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **1-833-711-4711 or 711** This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>8 a.m. – 8 p.m., Monday – Friday |
| **WRITE** | CareSource<br>P.O. Box 8738<br>Dayton, OH 45401-8738<br>If you are sending us an appeal or complaint, you can use the form in Chapter 9, *Section J, How to make a complaint*. You can also write a letter telling us about your question, problem, complaint, or appeal. |
| **WEBSITE** | **CareSource.com/MyCare** |

### A1. When to contact Member Services:

- questions about the plan
- questions about claims or billing from providers
- Member Identification (ID) Cards
    - Let us know if you didn't get your Member ID Card or you lost your Member ID Card.
- finding network providers
    - This includes questions about finding or changing your primary care provider (PCP).

- getting long-term services and supports
    - In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by Ohio Medicaid and CareSource MyCare Ohio, you may be able to get assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.
- understanding the information in your *Member Handbook*
- recommendations for things you think we should change
- other information about CareSource MyCare Ohio
    - You can ask for more information about our plan, including information regarding the structure and operation of CareSource MyCare Ohio and any physician incentive plans we operate.
- coverage decisions about your health care and drugs
    - A coverage decision is a decision about:
        - your benefits and covered services and drugs, **or**
        - the amount we will pay for your health services and drugs.
    - Call us if you have questions about a coverage decision.
    - To learn more about coverage decisions, refer to Chapter 9, Section D, *Coverage decisions and appeals*.
- appeals about your health care and drugs
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
    - To learn more about making an appeal, refer to Chapter 9, Section D, *Coverage decisions and appeals*.
- complaints about your health care and drugs
    - You can make a complaint about us or any provider or pharmacy. You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received (refer to Section E below page 23).
    - If your complaint is about a coverage decision about your health care or drugs, you can make an appeal (refer to the section above).

- You can send a complaint about CareSource MyCare Ohio right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- You can send a complaint about CareSource MyCare Ohio directly to Ohio Medicaid. Call 1-800-324-8680. This call is free. Refer to page 25 for other ways to contact Ohio Medicaid.
- You can send a complaint about CareSource MyCare Ohio to the MyCare Ohio Ombudsman. Call 1-800-282-1206. This call is free.
- To learn more about making a complaint, refer to Chapter 9, Section J, *How to make a complaint*.

- payment for health care or drugs you already paid for
  - For more on how to ask us to assist you with a service you paid for or to pay a bill you got, refer to Chapter 7, Section A, *Asking us to pay for your services or drugs*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section D, *Coverage decisions and appeals* for more on appeals.

## B. How to contact your Care Manager

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

At the time of your introductory outreach, you will meet your Care Manager and be given his/her contact information. Please allow 24 hours for a return phone call. If you are unable to reach your Care Manager or your Care Manager's supervisor after 24 hours, contact Member Services.

If you would like to change your Care Manager, you, your family, caregiver, legal guardian (person appointed by a court) or authorized representative may do so by contacting your Care Manager's supervisor. You may also call or write to us to request a change.

| | |
|---|---|
| **CALL** | **1-866-206-7861** This call is free.<br>The Care Manager call line is available 24 hours a day, 7 days a week, 365 days a year.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **1-833-711-4711 or 711** This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, 7 days a week, 365 days a year |
| **WRITE** | CareSource<br>P.O. Box 8738<br>Dayton, OH 45401-8738 |
| **WEBSITE** | **CareSource.com/MyCare** |

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

CareSource24® is our 24-hour nurse advice line. With CareSource24, you have unlimited access to talk with a caring and experienced staff of registered nurses through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource24 services are available at no cost to you. Our nurses can help you:

- Decide when self-care, a doctor visit or the emergency room is appropriate
- Understand an urgent illness or injury situation
- Get assistance with a personal crisis

| | |
|---|---|
| **CALL** | **1-866-206-7861** This call is free.<br>CareSource24® is available 24 hours a day, 7 days a week, 365 days a year.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **1-833-711-4711 or 711** This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, 7 days a week, 365 days a year |

### C1. When to contact the Nurse Advice Call Line

- questions about your health care

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

By calling the 24-Hour Behavioral Health Crisis Line you have unlimited access to talk with a caring and experienced staff of registered nurses through a toll-free number. You can call 24 hours a day, 7 days a week. This call is available to you at no cost. Our nurses can help you:

- decide when self-care, a doctor visit or emergency room is appropriate
- get in contact with your Care Manager
- get assistance with personal crisis

| | |
|---|---|
| **CALL** | **1-866-206-7861** This call is free.<br>The Behavioral Health Crisis Line is available 24 hours a day, 7 days a week, 365 days a year.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | **1-833-711-4711 or 711** This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, 7 days a week, 365 days a year |

### D1. When to contact the Behavioral Health Crisis Line

- questions about behavioral health services
- questions about substance use disorder services

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

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

| | |
|---|---|
| **CALL** | 1-888-524-9900 |
| **TTY** | 1-888-985-8775<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | 10820 Guilford Rd., Suite 202<br>Annapolis Junction, MD 20701 |
| **WEBSITE** | www.livantaqio.com |

### E1. When to contact Livanta

- questions about your health care
    - You can make a complaint about the care you got if you:
        - have a problem with the quality of care,
        - think your hospital stay is ending too soon, **or**
        - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

## F. How to contact Medicare

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

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

| | |
|---|---|
| **CALL** | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WEBSITE** | www.medicare.gov<br>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.<br>It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you. |

## G. How to contact the Ohio Department of Medicaid

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

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

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

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

## H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MyCare Ohio Ombudsman also helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan.

The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers getting long-term services and supports. The MyCare Ohio Ombudsman is not connected with our plan or with any insurance company or health plan. Their services are free.

| | |
|---|---|
| **CALL** | 1-800-282-1206 This call is free.<br>The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 am to 5:00 pm. |
| **TTY** | Ohio Relay Service: 1-833-711-4711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | Ohio Department of Aging<br>Attn: MyCare Ohio Ombudsman<br>30 E. Broad St., 22nd Floor<br>Columbus, Ohio 43215 |
| **WEBSITE** | www.aging.ohio.gov/wps/portal/gov/aging/care-and-living/get-help/get-an-advocate/my-care-ohio-ombudsman<br>You can submit an online complaint at: aging.ohio.gov/Contact. |

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

## Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with CareSource MyCare Ohio. It also tells you about your Care Manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable medical equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

## A. Information about "services," "covered services," "providers," "network providers," and "network pharmacies"

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

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

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

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you get. When you use a network pharmacy, you pay nothing for your prescription drugs. Refer to Chapter 6, Section C, *You pay nothing for a one-month or long-term supply of drugs* for more information.

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

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

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

- The care you get must be a **plan benefit**. Refer to Chapter 4, Section C, *Our plan's Benefits Chart* for information regarding covered benefits, including the plan's Benefits Chart.
- The care must be **medically necessary**. Medically necessary means you need services, supplies, or drugs to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment, or drugs meet accepted standards of medical practice.

- The care you get must be prior authorized by CareSource MyCare Ohio when required. For some services, your provider must submit information to CareSource MyCare Ohio and ask for approval for you to get the service. This is called prior authorization (PA). Refer to the chart in Chapter 4, Section D, *The Benefits Chart* for more information.

- You must choose a network provider to be your **primary care provider (PCP)** to manage your medical care. Although you do not need approval (called a referral) from your PCP to use other providers, it is still important to contact your PCP before you use a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.

    - To learn more about choosing a PCP, refer to page 32.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). Here are some cases when this rule does not apply:

    - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section H, page 39.

    - If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. *You must get prior authorization from CareSource MyCare Ohio before getting this care.* In this situation, we will cover the care at no cost to you. To learn about getting approval to use an out-of-network provider, refer to Section D, page 32.

    - The plan covers services you got at out-of-network Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the *Provider and Pharmacy Directory*.

    - If you are getting assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to get the services from that out-of-network provider.

    - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.

    - If you are new to our plan, you may be able to continue to use your current out-of-network providers for a period of time after you enroll. This is called a "transition period." For more information, refer to Chapter 1, Section F, *What to expect when you first join a health plan* of this handbook and your New Member Letter.

## C. Information about your care team and Care Manager

Your care team includes a group of people who can help you meet your goals for a healthy life. The team includes you, your health care providers, family members or caregivers and your CareSource MyCare Ohio Care Manager. Other team members may include, but are not limited to:

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

Your Care Manager helps you manage all of your providers and services. They work with your care team to make sure you get the care you need.

### C1. What care management is

Your Care Manager helps you manage all of your providers and services. He or she works with your care team to make sure you get the care you need. This includes 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 and behavioral health services. The Care Manager will be the main point of contact for your case and your care team.

### C2. How you can contact your Care Manager

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

### C3. How you will interact with your Care Manager and care team

Your care team may ask you questions to learn more about your health and your goals. The team will give you information to help you to understand how to care for yourself, obtain services you need, and connect with local resources. The team has your individualized needs as number one priority. The team can also work with you if you need help figuring out when to get medical care from your PCP, an urgent care center or the emergency room.

Everyone on your care team works together to make sure you receive coordinated care. This means that when tests and lab work are done, the results are shared with the appropriate providers. It means that your doctors know all of the medications you are taking so they can reduce any negative effects. Your Care Manager is a key member of your care team. He or she will focus on integrating your care to address all your needs. He or she will encourage your participation, so your goals are

always at the forefront. And, your Care Manager will conduct assessments, develop treatment plans, connect you to community resources, and perform ongoing evaluations as needed.

### C4. How you can change your Care Manager

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

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

### D1. Care from a primary care provider

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

#### Definition of "PCP" and what a PCP does

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

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

Sometimes there may be a reason that a specialist may need to be your PCP. An example might be if a specialist is managing your health care for an ongoing condition that impacts your overall health. If you and/or your specialist believe that they should be your PCP, you should call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday to discuss.

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

**Your choice of PCP**

The *Provider and Pharmacy Directory* is a list of doctors and other health care providers who accept CareSource MyCare Ohio members. If you haven't chosen a PCP yet, please choose one right away. It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can.

For the names of the PCPs in our network, you may look in your *Provider and Pharmacy Directory* if you requested a printed copy or visit our website at **CareSource.com/MyCare** and use our ***Find a Doctor/Provider*** tool. You may also call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday for help. If you are a new patient to your PCP, please call the office to schedule an appointment. This will help your PCP get to know you and understand your health care needs right away. You should also have all of your past medical records transferred to your new doctor.

**Option to change your PCP**

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

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

## D2. Care from specialists and other network providers

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

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

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

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

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

### D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Please remember that in most situations you must get prior authorization before you can use an out-of-network

provider. Refer to Section D4 below for information about how to get care from out-of-network providers.

- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make a complaint. Refer to Chapter 9, Section E, *Problems about services, items, and drugs (not Part D drugs)* for information about making an appeal.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday for help.

### D4. How to get care from out-of-network providers

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

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

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

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

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
- If you use a provider who is not eligible to participate in Medicare, you may have to pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

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

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

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

## F. How to get behavioral health services

If you already have a behavioral health care provider, we encourage you to continue seeing that provider for your treatment. If you need behavioral health and/or substance abuse services, please call either your Care Manager or Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You may also self-refer directly to an Ohio Department of Mental Health and Addiction Services (MHAS) facility and/or a certified community behavioral health provider. Please see your *Provider and Pharmacy Directory*, call Member Services or visit our website at **CareSource.com/MyCare** for the names and phone number of the facilities near you. You can also call us if you are in crisis. You can talk to someone right away and we can help you get the care you need. Just call our 24-hour behavioral health crisis line at **1-866-206-7861**.

## G. How to get transportation services

CareSource MyCare Ohio offers transportation services to approved health-related locations, if needed. Rides are available at no cost to you. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room. If you live in a long-term care facility and you require medical assistance for transport, someone who works at your facility will arrange transportation for you at no additional cost.

If you must travel 30 miles or more from your home to receive covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office. This part of the benefit is based on your location and is not subject to the 60 one-way trip limit.

## G1. How to get transportation services

- To arrange a ride, call CareSource MyCare Ohio at 1**-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.
- Please call as soon as you know you need a ride. Please call at least 48 hours (two business days) ahead of your doctor's visit. Saturday, Sunday, and holidays do not count.
- We cover up to 60 one-way trips per member per calendar year to any health care, Women, Infants, and Children (WIC), or redetermination appointments.

**CareSource MyCare Ohio Transportation Guidelines**

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

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

Member Transportation Responsibilities

1. Members should:
    - Call to arrange transportation 48 hours (two business days) in advance.
    - Know the complete address of the health care provider's office to which you are going.
    - Be sure your driver has enough travel time, so you are not late for your appointment.
    - Show your CareSource member ID card to the driver before using the transportation services.
    - Be ready when the driver gets there. The driver can wait for only five minutes. After five minutes, he or she will leave, and this will be considered a "no-show."
    - Call to cancel transportation at least two hours before your scheduled pick-up time if you are unable to make your appointment.
    - Ask the provider's office to call the transportation company for your return trip home.

2. Not showing for your scheduled ride affects how we serve other members in need. To help us provide the best transportation service for you and other members, please be sure you:
    - Are ready for pick-up at the earliest scheduled pick-up time.
    - Are ready to go when your driver arrives.
    - Call to cancel at least two hours before your scheduled pick-up time if you are unable to make your appointment.

The transportation company has the right to take away your transportation benefit for six months after three no-shows within three months. A no-show is defined as:

- Not being ready for pick-up at the earliest scheduled pick-up time.
- Not being available for your scheduled transportation and your driver waits for five minutes then leaves.
- You miss your scheduled transportation without cancelling at least two hours before the pick-up time. Each instance is reviewed on a case-by-case basis.

3. Members are expected to be courteous and show respect to the Transportation Company and CareSource MyCare Ohio staff. Improper behavior includes:
    - Use of profanity (swearing), name-calling, or verbal abuse.
    - Threats of physical abuse to the transportation company, drivers, or CareSource MyCare Ohio staff

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

Please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday if you have any questions or concerns.

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

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

## H1. Care when you have a medical emergency

### Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

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

### What to do if you have a medical emergency

If you have a medical emergency:

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

**Covered services in a medical emergency**

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D, *The Benefits Chart*.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call 1-800-488-0134. Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

**What to do if you have a behavioral health emergency**

If you have a behavioral health emergency, please contact either the Behavioral Crisis Line at **1-866-206-7861**, 24 hours a day, 7 days a week or the Suicide & Crisis Lifeline at 988 or 911.

Examples of behavioral health situations that may constitute an emergency include but are not limited to:

- Thinking about suicide or ending your life.
- Making choices that put you in serious danger such as reckless behavior or over-spending.
- Major changes in mood and behaviors such as:
    - Sadness that does not get better.
    - Feeling hopeless or helpless.
    - Feeling worthless.
    - Difficulty sleeping.
    - Changes in appetite or weight loss or weight gain.
    - Loss of interest or pleasure in doing things you normally enjoy.
- Becoming unable to care for yourself, placing yourself at risk of harm.
- Experiencing problems with your medication such as serious or uncomfortable side effects.

- Abuse of drug or alcohol.

**Getting emergency care if it wasn't an emergency**

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

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

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

## H2. Urgently needed care

**Definition of urgently needed care**

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

**Urgently needed care when you are in the plan's service area**

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

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

If you think you need to go to an urgent care center, you can:

- Call your PCP for advice. You can reach your PCP, or a back-up doctor, 24 hours a day, 7 days a week, or
- Call CareSource24, our 24-hour nurse advice line, at **1-866-206-7861**, or
- Call Teladoc, our on-demand telehealth services provider, at 1-800-TELADOC (835-2362), 24 hours a day, 7 days a week, or
- Go to a participating urgent care listed in your Provider and Pharmacy Directory or on our website at **CareSource.com/MyCare**. After you go, always call your PCP to schedule follow-up care.

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

**Urgently needed care when you are outside the plan's service area**

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

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

### H3. Care during a disaster

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

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

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

## I. What to do if you are billed directly for services covered by our plan

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

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

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you got a bill for covered services, **refer to Chapter 7, Section A, *Asking us to pay for your services or drugs* to learn what to do**.

### I1. What to do if services are not covered by our plan

CareSource MyCare Ohio covers all services:

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

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

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

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

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

## J. Coverage of health care services covered when you are in a clinical research study

### J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

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

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

If you want to participate in any Medicare-approved clinical research study, you do not need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do not need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

**We encourage you to tell us before you start participating in a clinical research study**. If you plan to be in a clinical research study, you or your Care Manager should contact Member Services to let us know you will be in a clinical trial.

### J2. Payment for services when you are in a clinical research study

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

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

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

**Ohio Medicaid does not cover clinical research studies**

### J3. Learning more about clinical research studies

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

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

### K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

### K2. Getting care from a religious non-medical health care institution

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

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

- "Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

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

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

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

## L. Durable medical equipment (DME)

### L1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of CareSource MyCare Ohio, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

### L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

**Note:** You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 11. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or Medicare Advantage plan.

### L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

### L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

# Chapter 4: Benefits Chart

## Introduction

This chapter tells you about the services CareSource MyCare Ohio covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents



## A. Your covered services

This chapter tells you what services CareSource MyCare Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section A, *Getting your prescriptions filled*, and information about what you pay for drugs is in Chapter 6, Section C, *You pay nothing for a one-month or long-term supply of drugs*.

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

If you need help understanding what services are covered or how to access services, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or your Care Manager at **1-866-206-7861**, 24 hours a day, 7 days a week.

## A1. During public health emergencies

During public health emergencies CareSource will follow guidance outlined by the Ohio Department of Medicaid and Centers for Disease Control and Prevention. Coverage and flexibilities related to the public health emergency will be determined when the public health emergency is declared. Any coverage and flexibilities related to the public health emergency are contingent upon the duration of the public health emergency. For additional information you can contact Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

CareSource MyCare Ohio will cover all COVID-19 testing, treatment, and vaccinations without copays.

### COVID-19 Testing

You can find COVID-19 testing locations online at coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/other-resources/testing-ch-centers.

### COVID-19 Vaccinations

The Ohio Department of Health (ODH) has a search tool you can use to find a vaccine provider. You can search the directory by county and ZIP code. It displays providers currently getting shipments of COVID-19 vaccines. You can get information and vaccination locations at vaccine.coronavirus.ohio.gov/ or by calling ODH toll-free at 833-427-5634.

CareSource MyCare Ohio can help you find a testing or vaccination location in your community. They also can help with scheduling and transportation to your appointment. Use the information at the bottom of the page to contact CareSource MyCare Ohio Member Services or the Nurse Advice Hotline at 1-866-206-7861.

ODH gives regular updates on vaccination eligibility phases at coronavirus.ohio.gov/wps/portal/gov/covid-19/covid-19-vaccination-program.

## B. Rules against providers charging you for services

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

**You should never get a bill from a provider for a covered service.** If you do, refer to Chapter 7, Section A, *Asking us to pay for your services or drugs* or call Member Services.

## C. Our plan's Benefits Chart

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

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

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
    - If CareSource MyCare Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, refer to Chapter 9, Section D, *Coverage decisions and appeals*.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.

- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to get the service. If you are not sure whether a service requires PA, contact Member Services or visit our website at **CareSource.com/oh/plans/MyCare/plan-documents**.

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

### D1. Preventive Visits

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Annual checkup**<br><br>This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months.<br><br>**Note**: You cannot have your first annual checkup within 12 months of your “Welcome to Medicare” preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a “Welcome to Medicare” visit first. | |
| **“Welcome to Medicare” visit**<br><br>If you have been in Medicare Part B for 12 months or less, you can get a one-time “Welcome to Medicare” preventive visit. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit. This visit includes:<br>• a review of your health,<br>• education and counseling about the preventive services you need (including screenings and shots), **and**<br>• referrals for other care if you need it. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Well child check-up (also known as Healthchek)**<br><br>Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.<br><br>Preventive checkups<br><br>Screenings: complete medical exams with a review of physical and mental health development, vision exams, dental exams, hearing exams, nutrition checks, developmental exams, lead testing if applicable.<br><br>Medically necessary follow-up care to treat physical, mental, or other health problems or issues found during a screening, including but not limited to:<br>• Visits with a primary care provider, specialist, dentist, optometrist and other CareSource providers to diagnose and treat problems.<br>• Inpatient or outpatient hospital care<br>• Clinic visits<br>• Prescription drugs<br>• All covered Healthchek services are provided at no cost up to age 21.<br>• Transportation to and from providers and assistance with scheduling health visits is available. | |

## D2. Preventive Services and Screenings

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Abdominal aortic aneurysm screening**<br><br>The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk. | You're considered at risk if you have a family history of abdominal aortic aneurysms, or you're a man 65-75 and have smoked at least 100 cigarettes in your lifetime. |
| **Alcohol misuse screening and counseling**<br><br>The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner. | |
| **Breast cancer screening**<br><br>The plan covers the following services:<br>• one baseline mammogram between the ages of 35 and 39<br>• one screening mammogram every 12 months for women age 40 and older<br>• women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms<br>• annual clinical breast exams | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)**<br><br>The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may:<br>• discuss aspirin use,<br>• check your blood pressure, **or**<br>• give you tips to make sure you are eating well. | |
| **Cardiovascular (heart) disease testing**<br><br>The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease. | |
| **Cervical and vaginal cancer screening**<br><br>The plan covers pap tests and pelvic exams annually for all women. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Colorectal cancer screening**<br><br>The plan will pay for the following services:<br>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema.<br>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema.<br>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.<br>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.<br>• Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.<br>• Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.<br><br>Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. | |
| **Counseling and interventions to stop smoking or tobacco use**<br><br>The plan covers tobacco cessation counseling and intervention. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Depression screening**<br><br>The plan covers depression screening. | |
| **Diabetes screening**<br><br>The plan covers diabetes screening (includes fasting glucose tests).<br><br>You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose). | |
| **HIV screening**<br><br>The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection. | |
| **Immunizations**<br><br>The plan covers the following services:<br>• vaccines for children under age 21<br>• pneumonia vaccine<br>• flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary<br>• hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B<br>• COVID-19 vaccine<br>• other vaccines if you are at risk and they meet Medicare Part B or Medicaid coverage rules<br>• other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D, *Vaccinations* to learn more. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Lung cancer screening**<br><br>The plan will pay for lung cancer screening every 12 months if you:<br>• are aged 50-77, **and**<br>• have a counseling and shared decision-making visit with your doctor or other qualified provider, **and**<br>• have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.<br><br>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider. | |
| **Medicare Diabetes Prevention Program (MDPP)**<br><br>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:<br>• long-term dietary change, **and**<br>• increased physical activity, **and**<br>• ways to maintain weight loss and a healthy lifestyle.<br><br>This program empowers patients with pre-diabetes to take charge of their health and well-being. Participants meet in groups with a trained lifestyle coach for 16 weekly sessions and 6-8 monthly follow-up sessions. These are not exercise classes. At these sessions patients learn ways to incorporate healthier eating and moderate physical activity, as well as problem-solving, stress-reduction and coping skills into their daily lives.<br><br>For more information on MDPP, call Solera at 1-844-612-2948 (TTY: 711), 8 a.m. – 8 p.m., Monday – Friday or visit GoSolera.com/MyCare. | |
| **Obesity screening and therapy to keep weight down**<br><br>The plan covers counseling to help you lose weight. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Prostate cancer screening**<br><br>The plan covers the following services:<br>• a digital rectal exam<br>• a prostate specific antigen (PSA) test | |
| **Sexually transmitted infections (STIs) screening and counseling**<br><br>The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B.<br><br>The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. | |

## D3. Other Services

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Acupuncture**<br><br>The plan covers acupuncture for pain management of headaches, lower back pain, neck pain, osteoarthritis of the hip or knee, nausea or vomiting related to pregnancy or chemotherapy, and acute post-operative pain.<br><br>The plan will also pay for up to 12 visits in 90 days if you have chronic low back pain, defined as:<br>• lasting 12 weeks or longer;<br>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);<br>• not associated with surgery; **and**<br>• not associated with pregnancy.<br><br>The plan will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments each year for chronic low back pain.<br><br>Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse. | Prior authorization is required for more than 30 acupuncture visits per benefit year. |
| **Ambulance and wheelchair van services**<br><br>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care.<br><br>Your condition must be serious enough that other ways of getting to a place of care could risk your health or, if you are pregnant, your unborn baby's life or health.<br><br>In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary. | Prior authorization is required for non-emergent air and ground transportation. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Annual Physical Exam**<br><br>This plan covers up to one physical exam every year. | |
| **Chiropractic services**<br><br>The plan covers:<br>• diagnostic x-rays<br>• adjustments of the spine to correct alignment | |
| **Dental services**<br><br>The plan covers the following services:<br>• comprehensive oral exam (one per provider-patient relationship)<br>• periodic oral exam<br>• preventive services including fluoride for members under age 21, prophylaxis (dental cleaning), sealants, and space maintainers<br>• routine radiographs/diagnostic imaging<br>• comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services<br><br>We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. | Periodic oral exams, prophylaxis (dental cleaning), and fluoride are covered once every 180 days.<br><br>Prior authorization may be required. Limitations may apply. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Diabetic services**<br><br>The plan covers the following services for all people who have diabetes (whether they use insulin or not):<br>• training to manage your diabetes, in some cases<br>• supplies to monitor your blood glucose, including:<br>  ○ blood glucose monitors and test strips<br>  ○ lancet devices and lancets<br>  ○ glucose-control solutions for checking the accuracy of test strips and monitors<br>• for people with diabetes who have severe diabetic foot disease:<br>  ○ one pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or**<br>  ○ one pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)<br><br>The plan also covers fitting the therapeutic custom-molded shoes or depth shoes. | Diabetic supplies are limited to the following manufacturers:<br><br>Blood glucose strips and meters: Abbott and Lifescan products<br><br>Continuous glucose monitors (CGMs): Abbott FreeStyle and Dexcom<br><br>Prior authorization is required, except for covered blood glucose monitoring supplies. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Durable medical equipment (DME) and related supplies**<br><br>Covered DME includes, but is not limited to, the following:<br>• wheelchairs<br>• crutches<br>• powered mattress systems<br>• diabetic supplies<br>• hospital beds ordered by a provider for use in the home<br>• intravenous (IV) infusion pumps<br>• speech generating devices<br>• oxygen equipment and supplies<br>• nebulizers<br>• walkers<br>• canes<br>• commodes<br><br>Other items (such as incontinence garments, enteral nutritional products, ostomy and urological supplies, and surgical dressings and related supplies) may be covered. For additional types of supplies that the plan covers, refer to the sections on diabetic services, hearing services, and prosthetic devices.<br><br>The plan may also cover learning how to use, modify, or repair your item. Your care team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan.<br><br>We will cover all DME that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Emergency care (refer to also "urgently needed care")**<br><br>Emergency care means services that are:<br>• given by a provider trained to give emergency services, **and**<br>• needed to treat a medical emergency.<br><br>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:<br>• serious risk to your health or if pregnant, to that of your unborn child; **or**<br>• serious harm to bodily functions; **or**<br>• serious dysfunction of any bodily organ or part; **or**<br>• in the case of a pregnant woman in active labor, when:<br>  ○ there is not enough time to safely transfer you to another hospital before delivery.<br>  ○ a transfer to another hospital may pose a threat to your health or to that of your unborn child.<br><br>In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting.<br><br>If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do.<br><br>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details. | If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, contact your Care Manager to arrange either authorization to stay in the non-network hospital or transition your care to a participating provider. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Family planning services**<br><br>The plan covers the following services:<br>• family planning exam and medical treatment<br>• family planning lab and diagnostic tests<br>• family planning methods (birth control pills, patch, ring, IUD, injections, implants)<br>• family planning supplies (condom, sponge, foam, film, diaphragm, cap)<br>• counseling and diagnosis of infertility, and related services<br>• counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions<br>• treatment for sexually transmitted infections (STIs)<br>• treatment for AIDS and other HIV-related conditions<br>• voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)<br>• screening, diagnosis, and counseling for genetic anomalies and/or hereditary metabolic disorders<br>• treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)<br><br>**Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Federally Qualified Health Centers**<br><br>The plan covers the following services at Federally Qualified Health Centers:<br>• office visits for primary care and specialist services<br>• physical therapy services<br>• speech pathology and audiology services<br>• dental services<br>• podiatry services<br>• optometric and/or optician services<br>• chiropractic services<br>• transportation services<br>• mental health services<br><br>**Note:** You can get services from a network or out-of-network Federally Qualified Health Center. | Prior authorization may be required. |
| **Flex Allowance**<br><br>Through the use of a debit card, members receive $500 per year for dental, hearing, and vision services and accessories when received from eligible providers. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Hearing services and supplies**<br><br>The plan covers the following:<br>• hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider)<br>• hearing aids, batteries, and accessories (including repair and/or replacement)<br>  ○ conventional hearing aids are covered once every 4 years<br>  ○ digital/programmable hearing aids are covered once every 5 years | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Home and community-based waiver services**<br><br>The plan covers the following home and community-based waiver services:<br>• adult day health services<br>• alternative meals service<br>• assisted living services<br>• choices home care attendant<br>• chore services<br>• community integration<br>• community transition<br>• enhanced community living services<br>• home care attendant<br>• home delivered meals<br>• home medical equipment and supplemental adaptive and assistive device services<br>• home modification, maintenance, and repair<br>• homemaker services<br>• independent living assistance<br>• medication dispenser<br>• medication reminder<br>• nutritional consultation<br>• out-of-home respite services<br>• personal care aide services<br>• personal emergency response services<br>• pest control<br><br>**This benefit is continued on the next page** | These services are available only if your need for long-term care has been determined by Ohio Medicaid.<br><br>You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.<br><br>Prior authorization is required.<br><br>Assisted living services – limited to one visit per calendar day.<br><br>Choices home care attendant – cannot be used concurrently with personal care services. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Home and community-based waiver services (continued)**<br>• social work counseling<br>• waiver nursing services<br>• waiver transportation<br><br>**This benefit is continued on the next page** | Community transition – only available if you are unable to meet such expenses or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended for purely diversion/recreational purposes. You may use this service in lieu of, but not in addition to the community transition service available through Ohio's Home Choice Money Follows the Person (MFP) demonstration program.<br><br>Community Transition Services are only available one time per waiver enrollment. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Home and community-based waiver services (continued)**<br><br>**This benefit is continued on the next page** | Emergency Response Services (ERS) does not include the following:<br>• Equipment that connects you directly to 911.<br>• Equipment such as a boundary alarm or any other equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.<br>• Remote monitoring services.<br>• Services performed in excess of what is approved pursuant to your waiver services plan. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Home and community-based waiver services (continued)** | • New equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse, or negligence, ERS and the providers of such services must be identified on the waiver service plan.<br><br>Home Medical Equipment & Supplemental Adaptive and Assistive Devices – Device Services shall not exceed a combined total of $10,000 within a calendar year per individual.<br><br>Home modification, supplemental adaptive equipment, and home maintenance & repair -limited to $10,000 for each service. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Home health services**<br><br>The plan covers the following services provided by a home health agency:<br>• home health aide and/or nursing services<br>• physical therapy, occupational therapy, and speech therapy<br>• private duty nursing (may also be provided by an independent provider)<br>• home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally<br>• medical and social services<br>• medical equipment and supplies | Prior authorization may be required. |
| **Home infusion therapy**<br><br>The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:<br>• the drug or biological substance, such as an antiviral or immune globulin;<br>• equipment, such as a pump; **and**<br>• supplies, such as tubing or a catheter.<br><br>The plan will cover home infusion services that include but are not limited to:<br>• professional services, including nursing services, provided in accordance with your care plan;<br>• member training and education not already included in the DME benefit;<br>• remote monitoring; **and**<br>• monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. | Prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Hospice care**<br>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider.<br>The plan will cover the following while you are getting hospice services:<br>• drugs to treat symptoms and pain<br>• short-term respite care<br>• home care<br>• nursing facility care<br>**Hospice services and services covered by Medicare Part A or B are billed to Medicare:**<br>• Refer to Section F of this chapter for more information.<br>**For services covered by CareSource MyCare Ohio but not covered by Medicare Part A or B:**<br>• CareSource MyCare Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services.<br>**For drugs that may be covered by CareSource MyCare Ohio's Medicare Part D benefit:**<br>• Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F, *Drug coverage in special cases*.<br>**This benefit is continued on the next page** | Prior authorization may be required.<br>Hospice is a Medicare benefit paid for by Original Medicare Part A when your meet specific criteria including your doctor(s) certifying that you are terminally ill, you accept palliative care instead of care to cure your illness, and you sign a statement choosing hospice care instead of other Medicare covered benefits to treat your terminal illness. If you choose to use hospice service while living in a nursing home your MyCare Medicaid benefit will pay for those services.<br>Additionally, you may be responsible for paying a patient liability during your hospice stay in a nursing facility. The County Department of Job and Family Services will let you know if you have a patient liability. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Hospice care (continued)**<br><br>**Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. If you do not know how to reach your Care Manager call Member Services.<br><br>Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit. | |
| **Inpatient behavioral health services**<br><br>The plan covers the following services:<br>• inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital<br>o For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit<br>• inpatient detoxification care | Prior authorization is required for all inpatient behavioral health services and some residential services for substance use disorder. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Inpatient hospital care**<br><br>The plan covers the following services, and maybe other services not listed here:<br>• semi-private room (or a private room if it is medically necessary)<br>• meals, including special diets<br>• regular nursing services<br>• costs of special care units, such as intensive care or coronary care units<br>• drugs and medications<br>• lab tests<br>• x-rays and other radiology services<br>• needed surgical and medical supplies<br>• appliances, such as wheelchairs for use in the hospital<br>• operating and recovery room services<br>• physical, occupational, and speech therapy<br>• inpatient substance use disorder services<br>• blood, including storage and administration<br>• physician/provider services<br>• in some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral<br><br>**This benefit is continued on the next page** | Prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Inpatient hospital care (continued)**<br><br>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. CareSource MyCare Ohio will arrange and/or cover transplant services at a distant location outside the service area if there are no providers within the service area and authorization is completed. If you choose to get your transplant there, we will arrange and/or cover lodging and travel costs for you and one other person if you must travel to a location outside the service area. | Prior authorization is required. |
| **Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay**<br><br>If your inpatient stay is not reasonable and necessary, the plan will not cover it.<br><br>However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here:<br>• doctor services<br>• diagnostic tests, like lab tests<br>• x-ray, radium, and isotope therapy, including technician materials and services<br>• surgical dressings<br>• splints, casts, and other devices used for fractures and dislocations<br><br>**This benefit is continued on the next page** | Prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)**<br>• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:<br>  ○ replace all or part of an internal body organ (including contiguous tissue), **or**<br>  ○ replace all or part of the function of an inoperative or malfunctioning internal body organ.<br>• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition<br>• physical therapy, speech therapy, and occupational therapy | Prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Kidney disease services and supplies**<br><br>The plan covers the following services:<br>• kidney disease education services to teach kidney care and help you make good decisions about your care<br>• outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan,* or when your provider for this service is temporarily unavailable or inaccessible<br>• inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care<br>• self-dialysis training, including training for you and anyone helping you with your home dialysis treatments<br>• home dialysis equipment and supplies<br>• certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply<br><br>**Note**: Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. | |
| **Meal Benefit**<br><br>Non-Medicare-covered meal benefit provides a maximum of 2 meals per day for 14 days following each observation or inpatient stay. | Community Well members only<br><br>Benefit is limited to $2,400 per year. |

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

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Medicare Part B prescription drugs**<br><br>These drugs are covered under Part B of Medicare. CareSource MyCare Ohio covers the following drugs:<br>• drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services<br>• insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)<br>• other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan<br>• clotting factors you give yourself by injection if you have hemophilia<br>• immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>• osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself<br>• antigens<br>• certain oral anti-cancer drugs and anti-nausea drugs<br>• certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)<br>• IV immune globulin for the home treatment of primary immune deficiency diseases<br><br>**This benefit is continued on the next page** | Prior authorization or step therapy is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Medicare Part B prescription drugs (continued)**<br><br>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.<br><br>Chapter 5, Section A, *Getting your prescriptions filled* explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.<br><br>Chapter 6, Section C, *You pay nothing for a one-month or long-term supply of drugs* explains what you pay for your outpatient prescription drugs through our plan. | Step therapy requires prior authorization based on clinical practice guidelines. |
| **Mental health and substance use disorder services at addiction treatment centers**<br><br>The plan covers the following services at addiction treatment centers:<br>• ambulatory detoxification<br>• assessment<br>• case management<br>• counseling<br>• crisis intervention<br>• intensive outpatient<br>• alcohol/drug screening analysis/lab urinalysis<br>• medical/somatic<br>• methadone administration<br>• office administered medications for addiction including vivitrol and buprenorphine induction<br>• partial hospitalization<br><br>Refer to “Inpatient behavioral health services” and “Outpatient mental health care” for additional information. | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Mental health and substance use disorder treatment services at community mental health centers**<br><br>The plan covers the following services at certified community mental health centers:<br>• mental health assessment/diagnostic psychiatric evaluation<br>• Assertive Community Treatment (ACT)<br>• Intensive Home Based Treatment (IHBT)<br>• Screening, Brief Intervention and Referral to Treatment (SBIRT)<br>• psychological testing<br>• Therapeutic Behavioral Services (TBS)<br>• psychosocial rehabilitation<br>• Community psychiatric supportive treatment (CPST) services<br>• counseling and therapy<br>• crisis intervention<br>• pharmacological management<br>• certain office administered injectable antipsychotic medications<br>• partial hospitalization for Substance Use Disorder only<br><br>Partial hospitalization is a structured program of active substance use disorder treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. Refer to "Inpatient behavioral health services" and "Outpatient mental health care" for additional information. | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Nursing and skilled nursing facility (SNF) care**<br><br>The plan covers the following services, and maybe other services not listed here:<br>• a semi-private room, or a private room if it is medically necessary<br>• meals, including special diets<br>• nursing services<br>• physical therapy, occupational therapy, and speech therapy<br>• drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors<br>• blood, including storage and administration<br>• medical and surgical supplies given by nursing facilities<br>• lab tests given by nursing facilities<br>• x-rays and other radiology services given by nursing facilities<br>• durable medical equipment, such as wheelchairs, usually given by nursing facilities<br>• physician/provider services<br><br>You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment:<br>• a nursing home or continuing care retirement community where you lived on the day you became a CareSource MyCare Ohio member<br><br>**This benefit is continued on the next page** | You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.<br><br>Note that patient liability does not apply to Medicare-covered days in a nursing facility.<br><br>When your care is covered by Medicaid, you usually pay nothing for covered services. However, you may have to pay a "patient liability." Patient liability is a cost you have to pay for some long-term care services. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Nursing and skilled nursing facility (SNF) care (continued)**<br><br>You can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment:<br>• a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)<br>• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital<br><br>**This benefit is continued on the next page** | Additional services that may be subject to patient liability include:<br>• Stay in a medical institution<br>• Stay in a long-term care facility<br>• Stay in Assisted Living Facility<br>• Have Home and community-based waiver services<br><br>Your patient liability for a month is based on your income. There are deductions that can decrease your patient liability. Your County Department of Job and Family Services caseworker will tell you if your income means you must pay this cost.<br><br>The patient liability amount will be the same every month. It will only change if there is an update to your income or deductions. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Nursing and skilled nursing facility (SNF) care (continued)** | You will not pay a patient liability for Medicare covered days.<br>Nursing and skilled nursing facilities require a prior authorization. |
| **Opioid treatment program (OTP) services**<br>The plan will pay for the following services to treat opioid use disorder (OUD):<br>• intake activities<br>• periodic assessments<br>• medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications<br>• substance use counseling<br>• individual and group therapy<br>• testing for drugs or chemicals in your body (toxicology testing) | Prior authorization is required for inpatient services. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Outpatient mental health care**<br><br>The plan covers mental health services provided by:<br>• a state-licensed psychiatrist or doctor,<br>• a clinical psychologist,<br>• a clinical social worker,<br>• a clinical nurse specialist,<br>• a licensed professional counselor (LPC),<br>• a licensed marriage and family therapist (LMFT),<br>• a nurse practitioner (NP),<br>• a physician assistant (PA), **or**<br>• any other qualified mental health care professional as allowed under applicable state laws.<br><br>The plan covers the following services, and maybe other services not listed here:<br>• Clinic services and general hospital outpatient psychiatric services<br>• Therapeutic Behavioral Services (TBS)<br>• Psychosocial rehab services<br>  ○ Assessments and testing<br>  ○ Pharmacy management and office visits<br>  ○ Individual and group counseling<br>  ○ Crisis intervention | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Outpatient services**<br><br>The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury.<br><br>The following are examples of covered services:<br>• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services<br>  ○ Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient."<br>  ○ Sometimes you can be in the hospital overnight and still be an "outpatient."<br>  ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101 http://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf<br>• the plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers<br>• chemotherapy<br>• labs and diagnostic tests (for example urinalysis)<br>• mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it<br>• imaging (for example x-rays, CTs, MRIs)<br>• radiation (radium and isotope) therapy, including technician materials and supplies<br>• blood, including storage and administration<br>• medical supplies, such as splints and casts<br>• preventive screenings and services listed throughout the Benefits Chart<br>• some drugs that you can't give yourself | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Over the Counter (OTC) Drug Benefit**<br><br>As an extra benefit, our plan covers up to $100 each quarter (every three months) using a debit card to purchase various OTC items via mail, or at select online and retail stores. Unused amounts do not roll over to the next quarter. | |
| **Partial hospitalization services and intensive outpatient services**<br><br>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.<br><br>Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. | Prior authorization may be required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Physician/provider services, including doctor's office visits**<br><br>The plan covers the following services:<br>• health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department<br>• consultation, diagnosis, and treatment by a specialist<br>• certain telehealth services, including, but not limited to, those for:<br>  ○ Medical Nutrition Therapy<br>  ○ smoking and tobacco use cessation counseling<br>  ○ psychiatric diagnostic evaluation<br>  ○ office or other outpatient visit for the evaluation and management of a new patient<br>• Teladoc® 24/7 at 1-800-TELADOC (835-2362) or visit www.Teladoc.com/MyCareOhio<br>• You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.<br><br>**This benefit is continued on the next page** | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Physician/provider services, including doctor's office visits (continued)**<br>• With telehealth services you can speak with and receive treatment from a physician over a secure, interactive audio and video connection that is supported by the use of mobile communication devices such as smartphones, tablets, and personal computers. This service is available 24 hours a day, 7 days a week, including holidays.<br>• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare.<br>• telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home<br>• telehealth services to diagnose, evaluate, or treat symptoms of a stroke<br>• telehealth services for members with a substance use disorder or co-occurring mental health disorder<br>• telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>o you have an in-person visit within 6 months prior to your first telehealth visit<br>o you have an in-person visit every 12 months while receiving these telehealth services<br>o exceptions can be made to the above for certain circumstances<br>• telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers<br>**This benefit is continued on the next page** | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Physician/provider services, including doctor's office visits (continued)**<br>• virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:<br>  ○ you're not a new patient **and**<br>  ○ the check-in isn't related to an office visit in the past 7 days **and**<br>  ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:<br>  ○ you're not a new patient **and**<br>  ○ the evaluation isn't related to an office visit in the past 7 days **and**<br>  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient<br>• second opinion by another network provider before surgery<br>• non-routine dental care. Covered services are limited to:<br>  ○ surgery of the jaw or related structures,<br>  ○ setting fractures of the jaw or facial bones,<br>  ○ pulling teeth before radiation treatments of neoplastic cancer, **or**<br>  ○ services that would be covered when provided by a physician | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Podiatry services**<br><br>The plan covers the following services:<br>• diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma<br>• routine foot care for members with conditions affecting the legs, such as diabetes | |
| **Prosthetic devices and related supplies**<br><br>Prosthetic devices replace all or part of a body part or function. The following are examples of covered prosthetic devices:<br>• colostomy bags and supplies related to colostomy care<br>• pacemakers<br>• braces<br>• prosthetic shoes<br>• artificial arms and legs<br>• breast prostheses (including a surgical brassiere after a mastectomy)<br>• dental devices<br><br>The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices.<br><br>The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section on page 97 for details. | Prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Rehabilitation services**<br>• outpatient rehabilitation services<br>  ○ The plan covers physical therapy, occupational therapy, and speech therapy.<br>  ○ You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.<br>• cardiac (heart) rehabilitation services<br>  ○ The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions.<br>  ○ The plan also covers intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.<br>• pulmonary rehabilitation services<br>  ○ The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). | Prior authorization may be required. |
| **Rural Health Clinics**<br>The plan covers the following services at Rural Health Clinics:<br>• office visits for primary care and specialist services<br>• clinical psychologist<br>• clinical social worker for the diagnosis and treatment of mental illness<br>• visiting nurse services in certain situations<br>**Note**: You can get services from a network or out-of-network Rural Health Clinic. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Specialized Recovery Services (SRS) Program**<br><br>If you are an adult who has been diagnosed with a severe and persistent mental illness and you live in the community, you may be eligible to get SRS specific to your recovery needs. The plan covers the following three services if you are enrolled in the SRS program:<br>• Recovery Management – Recovery managers will work with you to:<br>o develop a person-centered care plan which reflects your personal goals and desired outcomes,<br>o regularly monitor your plan through regular meetings, **and**<br>o provide information and referrals.<br>• Individualized Placement and Support-Supported Employment (IPS-SE) – Supported employment services can:<br>o help you find a job if you are interested in working,<br>o evaluate your interests, skills, and experiences as they relate to your employment goals, **and**<br>o provide ongoing support to help you stay employed.<br>• Peer Recovery Support:<br>o peer recovery supporters use their own experiences with mental health and substance use disorders to help you reach your recovery goals, **and**<br>o goals are included in a care plan you design based on your preferences and the availability of community and supports.<br><br>The peer relationship can help you focus on strategies and progress towards self-determination, self-advocacy, well-being, and independence. | If you are interested in SRS, you will be connected with a recovery manager who will begin the assessment for eligibility looking at things such as your diagnosis and your need for help with activities such as medical appointments, social interactions and living skills.<br><br>Medically necessary mental health specialty services are covered by CareSource at no cost to the individual and no prior authorization is required. |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Supervised exercise therapy (SET)**<br><br>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD). The plan will pay for:<br>• up to 36 sessions during a 12-week period if all SET requirements are met<br>• an additional 36 sessions over time if deemed medically necessary by a health care provider<br><br>The SET program must be:<br>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)<br>• in a hospital outpatient setting or in a physician's office<br>• delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD<br>• under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Transportation for non-emergency services (also refer to "Ambulance and wheelchair van services")**<br><br>CareSource MyCare Ohio offers transportation services, if needed. Plan-approved locations include:<br>• any health care<br>• Women, Infants and Children (WIC)<br>• redetermination appointments<br>• pharmacy<br>• gym<br>• grocery store<br><br>To arrange a ride, call CareSource MyCare Ohio at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Please call as soon as you know you need a ride. Please call at least 48 hours (two business days) in advance.<br><br>If you live in a long-term care facility and you require medical assistance for transport, someone who works at your facility will arrange transportation for you.<br><br>If you must travel 30 miles or more from your home to get covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office.<br><br>**Note**: In addition to the transportation assistance that CareSource MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services. | Up to 60 one-way or 30 round trips per member per calendar year |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Urgently needed care**<br><br>Urgently needed care is care given to treat:<br>• a non-emergency, **or**<br>• a sudden medical illness, **or**<br>• an injury, **or**<br>• a condition that needs care right away.<br><br>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).<br><br>Not covered outside the U.S. and its territories. | |

| Services covered by our plan | Limitations and exceptions |
|---|---|
| **Vision care**<br><br>The plan covers the following services:<br>• one comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered:<br>  ○ per 12-month period for members under 21 and over 59 years of age; **or**<br>  ○ per 24-month period for members 21 through 59 years of age.<br>• vision training<br>• services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to:<br>  ○ annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration<br>  ○ One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, members with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are age 65 and older.<br>  ○ One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) | |

## D. Services when you are away from home or outside of the service area

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

- If it's an emergency:
    - Call 911 or go to the nearest emergency room
- If it's not an emergency:
    - Call your PCP for help for what to do
- If you're not sure if it's an emergency:
    - Call your PCP **or**
    - Call CareSource24®, our 24-hour nurse line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711),** 24 hours a day, 7 days a week. We can help you decide what to do.

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

## E. Benefits covered outside of CareSource MyCare Ohio

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

### F1. Hospice care

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

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

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

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

**For services covered by Medicare Part A or B that are not related to your terminal prognosis:**

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

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

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

**Note:** If you need non-hospice care, you should call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Contact your Care Manager directly or call **1-866-206-7861**, 24 hours a day, 7 days a week.

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

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

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

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9, Section D, *Coverage decisions and appeals*.

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

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3, Section J, *Coverage of health care services covered when you are in a clinical research*

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

- Surgical treatment for morbid obesity, except when it is medically necessary and Medicare covers it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- Full-time nursing care in your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.

- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).

# Chapter 5: Getting your outpatient prescription drugs through the plan

## Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

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

### Rules for the plan's outpatient drug coverage

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

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
    - If it is not on the Drug List, we may be able to cover it by giving you an exception.
    - Refer to Chapter 9, Section F, *Part D drugs* to learn about asking for an exception.

5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.

## Table of Contents

# A. Getting your prescriptions filled

## A1. Filling your prescription at a network pharmacy

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

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

## A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

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

## A3. What to do if you change a prescription to a different network pharmacy

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

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

## A4. What to do if your pharmacy leaves the network

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

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

## A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

### A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List with MO (mail-order drug).

Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 102-day supply. A 102-day supply has the same copay as a one-month supply.

### Filling my prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call Express Scripts® at 1-800-354-3903.

Usually, a mail-order prescription will get to you within 7-10 days. However, sometimes your mail order may be delayed. If delivery of your medication does not arrive within 10 days, please call Express Scripts at 1-800-354-3903 to check on the status of your prescription. If your mail-order is delayed, you can go to the pharmacy for a one-time fill. If your medication requires a prior authorization, our mail-order pharmacy will contact your doctor. If the prescription is rejected or the medication is out of stock, our mail-order pharmacy will contact you and make arrangements for a two-week supply of your medication through a local retail pharmacy. For more information about mail order, visit our website at **CareSource.com/MyCare** or call Express Scripts at 1-800-354-3903 or call Member Services.

## Mail-order processes

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

1. **New prescriptions the pharmacy gets from you**

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

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

   The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

   - You used mail-order services with this plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by contacting Express Scripts at 1-800-354-3903.

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling Express Scripts at 1-800-354-3903.

   If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

   - This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped.
   - It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

   To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, please contact us by calling Express Scripts at 1-800-354-3903.

3. **Refills on mail-order prescriptions**

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by contacting Express Scripts at 1-800-354-3903.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. The pharmacy may have several ways you can communicate with them. You can call the mail-order pharmacy at 1-800-354-3903 to find out which option is best for you and let them know what you prefer.

## A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 102-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above, Section A6, *Using mail-order services to get your drugs* to learn about mail-order services.

## A8. Using a pharmacy that is not in the plan's network

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

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

- Special circumstances such as an emergency or an illness or injury while traveling outside of our service area where there are no network pharmacies.
- Day supply and step therapy requirements still apply at out of network pharmacies.

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby.

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

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7, Section A, *Asking us to pay for your services or drugs*.

## B. The plan's Drug List

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

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

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

### B1. Drugs on the Drug List

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

The Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

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

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

### B2. How to find a drug on the Drug List

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

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at **CareSource.com/MyCare**. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.caresource.com/oh/members/tools-resources/find-my-prescriptions/mycare or call your Care Manager or Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

### B3. Drugs that are not on the Drug List

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

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

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by CareSource MyCare Ohio for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor

might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

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

- drugs used to promote fertility
- drugs used for cosmetic purposes or to promote hair growth
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- drugs used for treatment of anorexia, weight loss, or weight gain
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

### B4. Drug List tiers

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

- Tier 1 includes generic drugs. This is the lowest tier.
- Tier 2 includes brand drugs.
- Tier 3 includes non-Part D drugs covered under the Medicaid benefit. This is the highest tier.

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

Chapter 6, Section C, *You pay nothing for a one-month or long-term supply of drugs* tells the amount you pay for drugs in each tier.

## C. Limits on some drugs

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

**If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug.** For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply

to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9, Section F, *Part D drugs*.

1. **Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available**

   Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies will give you the generic or interchangeable biosimilar version.

   - We usually will not pay for the brand name drug or original biological product when there is a generic version.
   - However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you or has written “No substitutions” on your prescription for a brand name drug or has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. **Getting plan approval in advance**

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

3. **Trying a different drug first**

   In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

   If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. **Quantity limits**

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

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

## D. Reasons your drug might not be covered

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

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above Section C, *Limits on some drugs*, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

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

### D1. Getting a temporary supply

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

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

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.
     - We will cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply will be for up to 30 days.

- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
  - We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan**.
  - This temporary supply will be for up to 30 days.
  - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - If you undergo a change in care, you are also eligible for a temporary supply to ensure you can continue your needed medications across care settings. This is called a level of care change and happens when you are released from a hospital or when you move to or from a long-term care facility.
    - If you move from a long-term care facility or hospital and need a temporary supply, we will cover one 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.
    - If you move from home or a hospital to a long-term care facility and need a temporary supply, we will cover one 31-day supply. If your prescription is written for few days, we will allow refills to provide up to a total of a 31-day supply.
  - To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

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

  **OR**

- You can ask for an exception.

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

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9, Section F, *Part D drugs*.

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

## E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but CareSource MyCare Ohio may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior authorization (PA) or approval for a drug. (PA is permission from CareSource MyCare Ohio before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless**:**

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check CareSource MyCare Ohio's up to date Drug List online at **CareSource.com/MyCare or**
- Call Member Services to check the current Drug List at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug or interchangeable biosimilar becomes available.** Sometimes, a new generic drug or an interchangeable biosimilar version of the same biological product comes on the market that works as well as a brand name or original biological product drug on the Drug List now. When that happens, we may remove the brand name drug or original biological product and add the new generic drug or an interchangeable biosimilar version of the same biological product, but your cost for the new drug or an interchangeable biosimilar will stay the same.

  When we add the new generic drug, we may also decide to keep the brand name drug or original biological product on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Your provider will also know about this change. He or she can work with you to find another drug for your condition.

**We may make other changes that affect the drugs you take.** We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9, Section F, *Part D drugs*.

**We may make changes that do not affect the drugs you take now**. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

## F. Drug coverage in special cases

### F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

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

### F2. If you are in a long-term care facility

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

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

### F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

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

To learn more about the hospice benefit, refer to Chapter 4, Section F, *Benefits covered outside of CareSource MyCare Ohio*.

## G. Programs on drug safety and managing drugs

### G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you are taking another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

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

## G2. Programs to help members manage their drugs

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

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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

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

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

## G3. Drug management program to help members safely use their opioid medications

CareSource MyCare Ohio has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of

prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

**You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know**. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9, Section D, *Coverage decisions and appeals*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

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

## Introduction

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

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

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

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

- The plan’s *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - which drugs the plan pays for
    - which of the 3 tiers each drug is in
    - whether there are any limits on the drugs
  - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at **CareSource.com/MyCare**. The Drug List on the website is always the most current.

- Chapter 5 of this *Member Handbook*.
    - Chapter 5, Section A, *Getting your prescriptions filled* tells how to get your outpatient prescription drugs through the plan.
    - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.
- The plan's *Provider and Pharmacy Directory*.
    - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
    - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, *Getting your prescriptions filled*.
    - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your Care Manager or Member Services for more information.

## Table of Contents

## A. The *Explanation of Benefits* (EOB)

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

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

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- To find out which drugs our plan covers, refer to the Drug List.

## B. How to keep track of your drug costs

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

1. **Use your Member ID Card.**

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

2. **Make sure we have the information we need.**

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

If you were unable to use a network pharmacy and had to pay for your prescription, refer to Chapter 7, Section A, *Asking us to pay for your services or drugs* for information about what to do.

**3. Check the EOBs we send you.**

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

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

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

### C1. The plan's tiers

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

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

### C2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 102-day supply. There is no cost to you for a long-term supply.

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

### C3. What you pay

Members who have CareSource MyCare Ohio coverage have no copays for prescription drugs.

| *Specialty medications do not qualify for a 102-day supply | **A network pharmacy**<br><br>A one-month or up to a 102-day supply | **The plan's mail-order service**<br><br>A one-month or up to a 102-day supply | **A network long-term care pharmacy**<br><br>Up to a 31-day supply | **An out-of-network pharmacy**<br><br>Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A, *Getting your prescriptions filled* for details. |
|---|---|---|---|---|
| **Tier 1**<br><br>(Part D generic drugs) | $0 | $0 | $0 | $0 |
| **Tier 2**<br><br>(Part D brand drugs) | $0 | $0 | $0 | $0 |
| **Tier 3**<br><br>(Medicaid-covered drugs) | $0 | $0 | $0 | $0 |

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

## D. Vaccinations

**Important Message About What You Pay for Vaccines:** Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs (Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccinations:

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

### D1. What you need to know before you get a vaccination

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

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

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

## Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

## A. Asking us to pay for your services or drugs

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

**If you get a bill for health care or drugs, call Member Services or send the bill to us.** To send us a bill, refer to page 129.

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

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

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

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

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

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

**2. When a network provider sends you a bill**

Network providers must always bill the plan for covered services. Show your CareSource MyCare Ohio Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because CareSource MyCare Ohio pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will work with the provider to refund your payment amount for your covered services.

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

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

You can always contact Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or your Care Manager at **1-866-206-7861**, 24 hours a day, 7 days a week if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 213 or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at **CareSource.com/oh/members/tools-resources/grievance-appeal/MyCare**

## B. How to avoid payment problems

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

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

**2. Get plan approval before going to an out-of-network provider.**

- Exceptions to this rule are:
  - if you need out-of-network emergency or urgent care services, **or**
  - if you get services at Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the *Provider and Pharmacy Directory*.
- If you get care from an out-of-network provider, ask the provider to bill CareSource MyCare Ohio.
  - If the out-of-network provider is approved by CareSource MyCare Ohio, you should not have to pay anything.
  - If the out-of-network provider will not bill CareSource MyCare Ohio and you pay for the service, call Member Services as soon as possible to let us know.
- Please remember that in most situations you must get plan approval before you can use an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval (PA) as indicated above, we may not pay for services you get from an out-of-network provider.

If you have questions about your transition of care period, whether you need approval to use a certain provider, or need help in finding a network provider, call Member Services.

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

Refer to Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan* for the rules about getting your health care, behavioral health, and other services. Refer to Chapter 5, Section A, *Getting your prescriptions filled* for the rules about getting your outpatient prescription drugs.

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

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

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

   If you forgot your Member ID Card, ask the provider to go online at **CareSource.com/MyCare** or to call 1-855-475-3163. If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

# Chapter 8: Your rights and responsibilities

## Introduction

In this chapter, you will find legal notices that apply to your membership in CareSource MyCare Ohio and your rights and responsibilities as a plan member. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

# A. Legal notices

## A1. Notices about laws

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

## A2. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, or sex.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at 1-888-278-7101.

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

## A3. Notice about Medicare as a second payer

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

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

## B. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. Each year you are in our plan, we must also tell you about the plan's benefits and your rights in a way that you can understand.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. Some written materials are available in Spanish. To receive this document in a language other than English or in an alternate format, please contact Member Services. We will keep a record of that request. For help or if you need to change your request, call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m. This call is free.

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also contact the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call 7-1-1.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Debemos asegurarnos de que todos los servicios se proporcionen de una manera culturalmente competente y accesible. Cada año que permanezca afiliado a nuestro plan, también debemos informarle de sus beneficios y derechos de una manera que pueda entenderlos.

- Para obtener información de una forma que sea comprensible para usted, llame a Servicios para Afiliados. Nuestro plan tiene servicios de intérprete gratuitos disponibles para responder preguntas en distintos idiomas.
- Nuestro plan también puede proporcionarle materiales en otros idiomas además del inglés y en otros formatos, como letras grandes, en braille o en audio. Algunos materiales escritos están disponibles en español. Para recibir este documento en otro idioma aparte del inglés o en un formato alternativo, comuníquese con Servicios para Afiliados. Nosotros guardaremos el registro de la solicitud. Para recibir ayuda o si necesita cambiar su solicitud, llame a Servicios para Afiliados al 1-855-475-3163

(TTY: 1-833-711-4711 o 711), de lunes a viernes, de 8 a. m. a 8 p. m. Esta llamada es gratuita.

Si tiene problemas para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad y desea presentar una queja, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- También puede comunicarse con la Línea directa de Medicaid de Ohio al 1-800-324-8680, de lunes a viernes, de 7:00 a. m. a 8:00 p. m., y los sábados, de 8:00 a. m. a 5:00 p. m. Los usuarios de TTY deben llamar al 7-1-1.
- Oficina de Derechos Civiles (Office of Civil Rights) al 1-800-368-1019 o TTY 1-800-537-7697.

## C. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to get all services that CareSource MyCare Ohio must provide and to choose the provider that gives you care whenever possible and appropriate.
- You have the right to be sure that others cannot hear or find you when you are getting medical care.
- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers*.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a network women's health specialist for covered women's health services without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.

  - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers*.

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

## D. Our responsibility to protect your personal health information (PHI)

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

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

### D1. How we protect your PHI

You have the right to be given information about your health. This information may also be available to someone who you have legally authorized to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.

We make sure that unauthorized people do not find or change your records.

Except for the cases noted below, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.

### D2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records if it isn't to transfer the records to a new provider.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

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

**Privacy Practices**

**This notice describes how health information about you may be used and given out. It also tells how you can get this information.** Please review it carefully. 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 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 our 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 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: HIPAAPrivacyOfficer@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 – Friday.

## E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of CareSource MyCare Ohio, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. This is a free service. Some written materials are available in Spanish. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including but not limited to:
  - financial information
  - how the plan has been rated by plan members
  - the number of appeals made by members
  - how to leave the plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers (PCP). You can change your PCP to another network PCP as often as once a month. We must send you something in writing that says who the new PCP is and the date the change began.
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - A list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at **CareSource.com/MyCare**.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - services and drugs covered by the plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

## F. Inability of network providers to bill you directly

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

## G. Your right to get your Medicare and Part D coverage from Original Medicare or another Medicare plan at any time by asking for a change

- You have the right to get your Medicare health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10, Section B, *How to change or end your membership in our plan* for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- You must continue to get your Medicaid services from a MyCare Ohio plan.

If you want to make a change, you can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY users should call 7-1-1), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.

## H. Your right to make decisions about your health care

### H1. Your right to know your treatment options and make decisions about your health care

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

- **Know your choices** and be told about all the kinds of treatment provided in a way appropriate to your condition and ability to understand.
- **Know the risks** and be told about any risks involved.
    - You must be told in advance if any service or treatment is part of a research experiment.
    - You have the right to refuse experimental treatments.

- **Get a second opinion** by using another qualified network provider before deciding on treatment.
    - If a qualified network provider is not able to find you, we will arrange a visit with a non-network provider at no cost to you.
- **Say "no"** and refuse any treatment or therapy.
    - This includes the right to:
        - leave a hospital or other medical facility, even if your doctor advises you not to.
        - stop taking a drug.
    - If you say no to treatment, therapy or taking a drug, the doctor or CareSource MyCare Ohio must talk to you about what could happen and they must put a note in your medical record.
    - If you refuse treatment or stop taking a drug, you will not be dropped from the plan.
    - However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care** and get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section D, *Coverage decisions and appeals* tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles** and refuse treatment from a student.

## H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

People often worry about the medical care they would get if they became too sick to make their wishes known.

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

You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

**This document explains your rights under Ohio law to accept or refuse medical care. The document also explains how you can state your wishes about the care you would want if you could not choose for yourself. This document does not contain legal advice, but will help you understand your rights under the law.**

**What are my rights to choose my medical care?**

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

**What if I am too sick to decide? What if I cannot make my wishes known?**

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you are able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

**What kinds of forms are there?**

Under Ohio law, there are four different forms, or advance directives, you can use: a Living Will, a Do Not Resuscitate (DNR) Order, a Health Care Power of Attorney (also known as a Durable Power of Attorney for Health Care) and a Declaration for Mental Health Treatment. You fill out an advance directive while you are able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

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

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

**Who can fill out an advance directive?**

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

**Do I need a lawyer?**

No, you do not need a lawyer to fill out an advance directive.

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

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

### Living Will

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

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

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

### Do Not Resuscitate Order

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

### Health Care Power of Attorney

A Health Care Power of Attorney is different from other types of powers of attorney. This document talks only about a Health Care Power of Attorney, not about other types of powers of attorney. A Health Care Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you cannot act for yourself. This could be for a short time period or for a long time period.

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

- When does my Health Care Power of Attorney take effect?
    - The form takes effect only when you can't choose your care for yourself. The form allows your relative or friend to stop life support only in the following circumstances:
        - If you are in a coma that is not expected to end, OR
        - If you are expected to die.

**Declaration for Mental Health Treatment**

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows you, while capable, to appoint a representative to make decisions on your behalf when you lack the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. For example, you can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

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

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

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

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

**Can I change my advance directives?**

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

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

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and cannot act for yourself.

**Where do I get advance directive forms?**

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

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

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends about what you have done. Do not just put these forms away and forget about them.

**Organ and Tissue Donation**

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

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

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State I.D. Card, OR
2. You may register online for organ donation through the Ohio Donor Registry website: www.donatelifeohio.org

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

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

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

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

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid community health agencies, or legal groups may also have advance directive forms. The forms are also currently available on the following website: www.proseniors.org/advance-directives/.

- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

### H3. What to do if your instructions are not followed

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

## I. Your right to make complaints and to ask us to reconsider decisions we have made

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

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

### I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

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

If you believe you have been treated unfairly and it is **not** about discrimination for the reasons listed in Chapter 11 or you would like more information about your rights, you can get help by calling:

- Member Services.
- The Ohio Medicaid Consumer Hotline at 1-800-324-8680 (TTY users call 7-1-1), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. Calls to this number are free.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The MyCare Ohio Ombudsman in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 am to 5:00 pm. Refer to Chapter 2, Section H, *How to contact the MyCare Ohio Ombudsman* for more information about this organization.

## J. Your responsibilities as a member of the plan

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

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to Chapters 3 and 4, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan* and Section D, *The Benefits Chart* respectively. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to Chapters 5 and 6, Section B, *The Plan's Drug List* and Section C, *You pay nothing for a one-month or long-term supply of drugs* respectively.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care** providers that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.

- **Help your doctors** and other health care providers give you the best care.
    - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For nearly all CareSource MyCare Ohio members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.
    - **If you get any services or drugs that are not covered by our plan, you may have to pay for the service or drug.** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9, Section D, *Coverage decisions and appeals* to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
    - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get CareSource MyCare Ohio. Chapter 1, Section D, *CareSource MyCare Ohio's service area* tells about our service area.
    - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.

- Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2, Section F, *How to contact Medicare* and Section G, *How to contact the Ohio Department of Medicaid* for phone numbers for Medicare and Medicaid.
- **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you. Refer to Section K in Chapter 1 for more information. You must also notify your County Caseworker at the local Department of Job and Family Services.

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

### J1. Estate recovery program

If you are permanently institutionalized or age 55 or older when you get Medicaid benefits, the Estate Recovery Program may recover payments from your estate for the cost of your care paid by Ohio Medicaid. The cost of your care may include the capitation payment that Ohio Medicaid pays to your managed care plan, even if the payment is greater than the cost of the services you got. Estate recovery happens after your death.

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

## Introduction

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

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

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

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter explains the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services. **You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 to help guide you through your problem.**

For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section H, *How to contact the MyCare Ohio Ombudsman* for more information on ombudsman programs.

## Table of Contents

# A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

## A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

# B. Where to call for help

## B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. You can contact any of the following resources for help.

### Getting help from CareSource MyCare Ohio’s Member Services

Member Services can help you with any problems or complaints about your health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. The call is free.
- Visit our website at **CareSource.com/MyCare** to send a question, complaint, or appeal.

- Fill out the appeal/complaint form on page 209 of this chapter or call Member Services and ask us to mail you a form.
- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio Member ID Card, and your address and telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

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

**Getting help from the Ohio Department of Medicaid**

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do about your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572), Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. The call is free. You can also visit the Ohio Department of Medicaid website at www.medicaid.ohio.gov.

**Getting help from the MyCare Ohio Ombudsman**

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman is an ombudsman program that can help you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. Refer to Chapter 2, Section H, *How to contact the MyCare Ohio Ombudsman* for more information on ombudsman programs.

The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8:00 am to 5:00 pm. You can also submit an online complaint at: aging.ohio.gov/contact. The services are free.

**Getting help from Medicare**

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

**Getting help from other resources**

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or other provider that requested the service can submit a Level 1 appeal on your behalf.
    - If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name them as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your "representative."
    - If you want someone to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at **CareSource.com/MyCare**. The form gives the person permission to act for you. You must give us a copy of the signed form.
    - We will also accept a letter or other appropriate form to authorize your representative.
- You can talk to a lawyer. You may call your own lawyer or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Aid toll-free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

## C. Problems with your benefits

### C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

| **Is your problem or concern about your benefits or coverage?**<br><br>(This includes problems about whether particular medical care (medical items, services, and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.) | |
|---|---|
| **Yes.**<br>My problem is about benefits or coverage.<br><br>Refer to Section D: **"Coverage decisions and appeals"** on page 162. | **No.**<br>My problem is not about benefits or coverage.<br><br>Skip ahead to Section J: **"How to make a complaint"** on page 203. |

# D. Coverage decisions and appeals

## D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

### What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

### What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagree with our decision, you can appeal.

### How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources listed in Section B1 on page 159.

## D2. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- Section E on page 164 gives you information if you have problems getting medical care or items, dental or vision services, behavioral health services, long-term services and supports, and prescription drugs (but **not** Part D drugs). For example, use this section if:
    - You are not getting medical care you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
        - **NOTE:** Only use Section E for problems with drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with a * (non-Part D drugs) are **not** covered by Part D. Refer to Section F on page 180 for Part D drug appeals.
    - You got medical care or services you think should be covered, but we are not paying for this care.
    - You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
        - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 191 and 197.
    - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will

send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- Section F on page 180 gives you information if you have problems about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought so your payment can be refunded. (This is asking for a coverage decision about payment.)
- Section G on page 191 gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- Section H on page 197 gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

If you need other help or information, please call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

## E. Problems about services, items, and drugs (not Part D drugs)

### E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical care or items, dental or vision services, behavioral health services, and long-term services and supports. You can also use this section for problems with drugs that are **not** covered by Part D, including

Medicare Part B drugs. Drugs in the Drug List with a * (non-Part D drugs) are not covered by Part D. Use Section F for Part D drug appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   **What you can do:** You can ask us to make a coverage decision. Refer to Section E2 on page 167 for information on asking for a coverage decision.

2. You want us to cover a benefit that requires plan approval (also called prior authorization (PA)) before you get the service.

   **What you can do:** You can ask us to make a coverage decision. Refer to Section E2 on page 167 for information on asking for a coverage decision.

   **NOTE:** Refer to the Benefits Chart in Chapter 4, Section D, *The Benefits Chart* for a general list of covered services as well as information on what services require PA from our plan. Refer to the Drug List to find out if any drugs require PA. You can also find the lists of services and drugs that require PA at **CareSource.com/MyCare**.

3. We did not approve care your doctor wants to give you, and you think we should have.

   **What you can do:** You can appeal our decision to not approve the care. Refer to Section E3 on page 169 for information on making an appeal.

4. We did not approve your request to get waiver services from a specific network non-agency or participant-directed provider.

   **What you can do:** You can appeal our decision to not approve the request. Refer to section E3 on page 169 for information on making an appeal.

5. You got services or items that you think we cover, but we will not pay.

   **What you can do:** You can appeal our decision not to pay. Refer to Section E3 on page 169 for information on making an appeal.

6. You got and paid for services or items you thought were covered, and you want us to work with the provider to refund your payment.

   **What you can do:** You can ask us to work with the provider to refund your payment. Refer to page 178 of this section for information on asking for payment.

7. We reduced, suspended, or stopped your coverage for a certain service or item, and you disagree with our decision.

**What you can do:** You can appeal our decision to reduce, suspend, or stop the service or item. Refer to Section E3 on page 169 for information on making an appeal.

**NOTE:** If we tell you that previously approved services or items will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to get the services and items during the appeal. Read “Will my benefits continue during Level 1 appeals” on page 174.

**NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 191 and 197 to find out more.

8. We did not make a coverage decision within the timeframes we should have.

   **What you can do:** You can file a complaint or an appeal. Refer to Section J on page 203 for information on making a complaint. Refer to Section E3 on page 169 for information on making a Level 1 Appeal.

   **NOTE:** If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

9. We did not make an appeal decision within the timeframes we should have.

   **What you can do:** You can file a complaint. Refer to Section J on page 203 for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing. Refer to Section E4 on page 174 for information on asking for a State Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

   **NOTE:** If you need help deciding which process to use, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

## E2. Asking for a coverage decision

**How to ask for a coverage decision to get a service, item, or Medicaid drug** (refer to Section F for Medicare Part D drugs)

To ask for a coverage decision, call, write, or fax us, or ask your authorized representative or doctor to ask us for a decision.

- You can call us at: **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**
- You can fax us at: **1-855-489-3403**
- You can write to us at:

  CareSource MyCare Appeals
  P.O. Box 1947
  Dayton, OH 45401-1947

Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, refer to Section B1 on page 159.

### How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid or Medicare Part B prescription drugs within 72 hours after we receive your request.

We will make a standard coverage decision on all other services and items within 10 calendar days after you asked. If we don't give you our decision within 10 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

### Can I get a coverage decision faster?

**Yes**. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 24 hours for Medicaid or Medicare Part B prescription drugs and within 48 hours for all other services and items.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

**Asking for a fast coverage decision:**

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or fax us at **1-855-489-3403**. For details on how to contact us, refer to Chapter 2, Section A, *How to contact CareSource MyCare Ohio Member Services*.
- You can also have your doctor or your authorized representative call us.

**Here are the rules for asking for a fast coverage decision:**

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical items and/or services you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for items or services you already got.)
2. You can get a fast coverage decision **only if the standard deadlines could cause serious harm to your health or hurt your ability to function**. The standard deadlines are 72 hours for Medicaid or Medicare Part B prescription drugs and 10 calendar days for all other services and items.
    - If your doctor says that you need a fast coverage decision, we will automatically give you one.
    - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
        - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines (72 hours for Medicaid or Medicare Part B prescription drugs) instead to make our decision.
        - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
        - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For

more information about the process for making complaints, including fast complaints, refer to Section J on page 203.

**If the coverage decision is No, how will I find out?**

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

## E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

**What is an Appeal?**

An appeal is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or other provider disagree with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. We will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

**NOTE:** If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name them as your representative in writing. Read “Can someone else make the appeal for me” on page 170 for more information.

If you need help during the appeals process, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750). The MyCare Ohio Ombudsman is not connected with us or with any insurance company or health plan.

### What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

**At a glance: How to make a Level 1 Appeal**

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

### How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or other provider must contact us. You can call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or write to us at the following address:

  CareSource MyCare Appeals
  P.O. Box 1947
  Dayton, OH 45401-1947

- If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 209. Be sure to include your first and last name, the number from the front of your CareSource MyCare Ohio Member ID Card, and your address and telephone number. You should also include any information that helps explain your problem.
- For additional details on how to reach us for appeals, refer to Chapter 2, Section A, *How to contact CareSource MyCare Ohio Member Services*.
- You can ask us for a “standard appeal” or a “fast appeal.”

**The legal term** for “fast appeal” is **“expedited reconsideration.”**

### Can someone else make the appeal for me?

**Yes**. Your doctor or other provider can make the appeal for you. Also, someone else can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at **CareSource.com/oh/members/tools-resources/forms/mycare**. We will also accept a letter or other appropriate form to authorize your representative.

**If the appeal comes from someone besides you or your doctor or other provider that requested the service**, we must get your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf, we must get your written authorization.

### How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** after the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

**NOTE:** If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 174 for more information.

### Can I get a copy of my case file?

**Yes**. Ask us for a free copy by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

### Can my doctor give you more information about my appeal?

**Yes**, you and your doctor may give us more information to support your appeal.

### How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to find out if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

**When will I hear about a "standard" appeal decision?**

We must give you our answer within 15 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 203.
- If we do not give you an answer to your appeal within 15 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to Section E4 on page 174). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to Section E4 on page 174).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 203).

**If our answer is Yes** to part or all of what you asked for, we must approve the service within 15 calendar days after we get your appeal (or within 7 days after we get your appeal for a Medicare Part B prescription drug).

**If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (refer to Section E4 on page 174). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 174).

**When will I hear about a "fast" appeal decision?**

If you ask for a fast appeal, we will give you our answer within 72 hours after we get all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 203.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item (refer to Section E4 on page 174). You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing (refer to Section E4 on page 174).

You can also file a complaint about our failure to make an appeal decision within the required timeframe (refer to Section J on page 203).

**If our answer is Yes** to part or all of what you asked for, we must authorize the coverage within 72 hours after we get your appeal.

**If our answer is No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal (refer to Section E4 on page 174). If your problem is about coverage of a Medicaid service or item, the letter will tell you that you can also request a State Hearing (refer to Section E4 on page 174).

**Will my benefits continue during Level 1 appeals?**

**Yes**, if you meet certain requirements. If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or other provider must **ask for an appeal on or before the later of the following** to continue the service during the appeal:

- Within 15 calendar days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; or (2) 15 calendar days pass after we notify you that we said **No** to your appeal.

**NOTE:** Sometimes your benefits may continue even if we say **No** to your appeal. If the service is covered by Medicaid and you ask for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision. If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process. For more information, refer to Section E4 on page 174.

## E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

**If the plan says No at Level 1, what happens next?**

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicaid** service or item, the letter will tell you that you may ask for a State Hearing. Refer to page 175 of this section for information on State Hearings.
- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that could be primarily covered by **both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will tell you that you may also ask for a State Hearing. Refer to page 175 of this section for information on State Hearings.

### What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

### My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

If we say **No** to your Appeal at Level 1 and the service or item is usually covered by Medicaid, you may ask for a State Hearing.

### What is a State Hearing?

A State Hearing is a meeting with you or your authorized representative, our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think our plan did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

We will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver *Member Handbook* for more information about your rights.

### How do I ask for a State Hearing?

To ask for a State Hearing, you or your authorized representative must contact the Bureau of State Hearings **within 90 calendar days** of the date that we sent the notice of your State Hearing rights. The 90 calendar days begins on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. Remember, you have to ask for a Level 1 Appeal before you can ask for a State Hearing.

**NOTE:** If you want someone to act on your behalf, including your doctor or other provider, you must give the Bureau of State Hearings written notice saying that you want that person to be your authorized representative.

- You can sign and send the State Hearing form to the address or fax number listed on the form or submit your request by e-mail to bsh@jfs.ohio.gov. You can also call the Bureau of State Hearings at 1-866-635-3748.

### How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the Bureau of State Hearings gets your request. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed, but no later than 3 working days after the Bureau of State Hearings gets your request.

**My problem is about a service or item that is covered by Medicare. What will happen at the Level 2 Appeal?**

If we say No to your Appeal at Level 1 and the service or item is usually covered by Medicare, you will automatically get a Level 2 Appeal from the Independent Review Entity (IRE). An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

**How long does it take to get an IRE decision?**

- The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.
    - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.
    - However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

**What if my service or item is covered by both Medicare and Medicaid?**

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity. You can also ask for a State Hearing. To ask for a State hearing, follow the instructions in this section on page 175.

**Will my benefits continue during Level 2 appeals?**

If we decide to change or stop coverage for a service that was previously approved, you can ask to continue your benefits during Level 2 Appeals in some cases.

- If your problem is about a service primarily covered by **Medicaid only,** you can ask to continue your benefits during Level 2 appeals. You or your authorized representative must **ask for a State Hearing before the later of the following** to continue the service during the State Hearing:
  - Within 15 calendar days of the mailing date of our letter telling you that we denied your Level 1 appeal; **or**
  - The intended effective date of the action.
- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the Independent Review Entity (IRE).
- If your problem is about a service primarily covered by **both Medicare and Medicaid**, your benefits for that service will automatically continue during the Level 2 appeal process with the IRE. If you also ask for a State Hearing, you can continue your benefits while the hearing is pending if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; (2) all entities that got your Level 2 Appeal (the IRE and/or Bureau of State Hearings) decide **No** to your request.

**How will I find out about the decision?**

If your Level 2 Appeal was a State Hearing, the Bureau of State Hearings will send you a written hearing decision in the mail.

- If the hearing decision is **Yes** (sustained) to all or part of what you asked for, the decision will clearly explain what our plan must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services for assistance.
- If the hearing decision is **No** (overruled) to part or all of what you asked for, it means the Bureau of State Hearings agreed with the Level 1 decision. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying No and will tell you that you have the right to request an Administrative Appeal.

If your Level 2 Appeal went to the Independent Review Entity (IRE), the Independent Review Entity (IRE) will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

**I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?**

If either the Independent Review Entity or the Bureau of State Hearings decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

**If the decision is No for all or part of what I asked for, can I make another appeal?**

If your Level 2 Appeal was a State Hearing, you can appeal again by asking for an Administrative Appeal. The Bureau of State Hearings must get your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I on page 202 for more information on additional levels of appeal.

## E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

For more information, start by reading Chapter 7: “Asking us to pay a bill you have gotten for covered services or drugs.” Chapter 7 describes the situations in which you may need to ask us to assist you with payment you made to a provider or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment. Chapter 7 also gives information to help you avoid payment problems in the future.

**Can I ask you to pay me back for a service or item I paid for?**

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will work with the provider to refund your payment.
- If you haven’t paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it’s the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

**What if we say we will not pay?**

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 169. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking to be paid back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should make payment, we must send the payment to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 202 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid, you can request a State Hearing (refer to Section E4 on page 174).

## F. Part D drugs

### F1. What to do if you have problems getting a Part D drug or you want your payment refunded for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with a * (non-Part D drugs). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with * symbol follow the process in Section E on page 164.

**Can I ask for a coverage decision or make an appeal about Part D prescription drugs?**

**Yes**. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List, but we require you to get approval from us before we will cover it for you).

**NOTE:** If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services for assistance.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

| **Which of these situations are you in?** | | | |
|---|---|---|---|
| Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? | Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? | Do you want to ask us to pay you back for a drug you already got and paid for? | Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? |
| **You can ask us to make an exception.** (This is a type of coverage decision.) | **You can ask us for a coverage decision.** | **You can ask us to pay you back.** (This is a type of coverage decision.) | **You can make an appeal.** (This means you are asking us to reconsider.) |
| Start with Section F2 on page 182. Also refer to Sections F3 and F4 on pages 183 and 184. | Skip ahead to Section F4 on page 184. | Skip ahead to Section F4 on page 184. | Skip ahead to Section F5 on page 187. |

## F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5, Section B, *The plan's Drug List*).

    - The extra rules and restrictions on coverage for certain drugs include:

        - Being required to use the generic version of a drug instead of the brand name drug.

        - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization" (PA).)

        - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")

        - Quantity limits. For some drugs, we limit the amount of the drug you can have.

> **The legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

## F3. Important things to know about asking for exceptions

### Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

### We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 187 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

## F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

### What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section B on page 159 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.

**At a glance: How to ask for a coverage decision about a Part D drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from the doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you paid for a drug that you think should be covered, read Chapter 7, Section A, *Asking us to pay for your services or drugs* of this handbook. Chapter 7 tells how to call Member Services or send us the paperwork that asks us to cover the drug.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

**If your health requires it, ask us to give you a "fast coverage decision"**

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.**

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 203.

**Deadlines for a "fast coverage decision"**

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

**Deadlines for a "standard coverage decision" about a drug you have not yet received**

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

**Deadlines for a "standard coverage decision" about payment for a drug you already bought**

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

## F5. Level 1 Appeal for Part D drugs

To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.

If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

If you want a fast appeal, you may make your appeal in writing or you may call us.

Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

**At a glance: How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

**The legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

**If your health requires it, ask for a "fast appeal"**

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4 on page 184.

> **The legal term** for "fast appeal" is **"expedited redetermination."**

**Our plan will review your appeal and give you our decision**

- We take another careful look at all of the information about your coverage request. We check to find out if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

**Deadlines for a "fast appeal"**

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

**Deadlines for a "standard appeal"**

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.

- **If our answer is Yes** to part or all of what you asked for:
  - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
  - If we approve a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

### F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will automatically send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.
- You have a right to give the IRE other information to support your appeal.

**At a glance: How to make a Level 2 Appeal**

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

> **The legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."**

**Deadlines for "fast appeal" at Level 2**

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

**Deadlines for "standard appeal" at Level 2**

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
    - If the IRE approves a request to cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

**What if the Independent Review Entity says No to your Level 2 Appeal?**

**No** means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE with the decision of your Level 2 appeal will tell you the dollar value needed to continue with the appeal process.

## G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

### G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don’t understand. The “Important Message” tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

### G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you.

In Ohio, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

**Call right away!**

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. An Important Message from Medicare about Your Rights contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do not call to appeal, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.

**At a glance: How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for a “fast review.”

Call before you leave the hospital and before your planned discharge date.

- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 195.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You can also call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

### What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

### Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> **The legal term** for "fast review" is **"immediate review."**

### What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> **The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

### What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

**What if the answer is No?**

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

## G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

**At a glance: How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for another review.

**What happens if the answer is Yes?**

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

**What happens if the answer is No?**

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

## G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

**Level 1 Alternate Appeal to change your hospital discharge date**

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to find out if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a “fast review.”

**At a glance: How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
    - It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> **The legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

### Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 203 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

**At a glance: How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

# H. What to do if you think your Medicare home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only when they are covered by Medicare:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

## H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.” The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying the cost for your care.

## H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 203 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Or call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

**At a glance: How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

### What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by the federal government to check on and help improve the quality of care for people with Medicare.

### What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

### What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 200.

> **The legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

**What happens during the Quality Improvement Organization's review?**

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> **The legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

**What happens if the reviewers say Yes?**

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

**What happens if the reviewers say No?**

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

### H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Ohio, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

**At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization for your state at 1-888-524-9900 (TTY: 1-888-985-8775) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

**What happens if the review organization says Yes?**

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

**What happens if the review organization says No?**

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

### H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

### Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to find out if the decision about when your services should end was fair and followed all the rules.

**At a glance: How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services. To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> **The legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

### Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 203 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

**At a glance: How to make a Level 2 Appeal to require that the plan continue your care**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

## I. Taking your appeal beyond Level 2

### I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can contact the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MyCare Ohio Ombudsman. The phone number is 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

### I2. Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at 1-866-635-3748.

## J. How to make a complaint

### J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, receiving a bill, and customer service. Here are examples of the kinds of problems handled by the complaint process.

**Complaints about quality**

- You are unhappy with the quality of care, such as the care you got in the hospital.

**Complaints about privacy**

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

**Complaints about poor customer service**

- A health care provider or staff was rude or disrespectful to you.
- CareSource MyCare Ohio staff treated you poorly.
- You think you are being pushed out of the plan.

**At a glance: How to make a complaint**

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 207.

If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).

**Complaints about accessibility**

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

**Complaints about waiting times**

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

**Complaints about cleanliness**

- You think the clinic, hospital or doctor's office is not clean.

**Complaints about language access**

- Your doctor or provider does not provide you with an interpreter during your appointment.

**Complaints about receiving a bill**

- Your doctor or provider sent you a bill.

**Complaints about communications from us**

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

**Complaints about the timeliness of our actions related to coverage decisions or appeals**

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

> **The legal term** for a "complaint" is a **"grievance."**
>
> **The legal term** for "making a complaint" is **"filing a grievance."**

**Are there different types of complaints?**

**Yes**. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. **If you need help making an internal and/or external complaint, you can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).**

## J2. Internal complaints

To make an internal complaint, Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday. Complaints related to Part D must be made **within 60 calendar days** after you had the problem you want to complain about. All other complaints can be made **at any time** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can also use the form on page 209 to submit the complaint.
- Specifically, if you would like to file a complaint, you can do so in any of the following ways:
    - Call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday, or
    - Fill out the *Member Grievance/Appeal Form* available online or on page 209, or
    - Write a letter telling us what you are unhappy about.

Be sure to put your first and last name, the number from the front of your CareSource Member ID card, and your address and telephone number in the letter so that we can contact you, if needed. Please send any information that helps explain your problem.

Mail the form or your letter to:

CareSource MyCare Complaints
P.O. Box 1307
Dayton, OH 45401-1307

If your grievance is about getting a bill for care you or a family member received, please call the telephone number on the bill to make sure they have your CareSource MyCare Ohio ID number or to give them the primary insurance for the family member who received the care. If they tell you they have this information, please ask them why you are receiving a bill.

After you have done this, please contact Member Services and provide us with the following information on your bill:

- The date of service
- The amount of the bill
- The provider's name
- The telephone number
- The account number
- Tell us why the provider's office told you they were billing you

If you are not happy with our answer to your grievance, please contact Member Services, and we will be happy to discuss it with you.

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

Ohio Department of Medicaid
Bureau of Managed Care
P.O. Box 182709
Columbus, OH 43218-2709

If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically file a "fast complaint" for you and respond to your complaint within 24 hours.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer complaints about access to care within 2 business days. We answer all other complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

**If we do not agree** with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

## J3. External complaints

### You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

### You can tell Medicaid about your complaint

You can call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

### You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr.

You may also contact the local Office for Civil Rights office at:

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act and under Ohio Revised Code 4112.02. You can contact Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday or the Ohio Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572) for assistance.

### You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us **and** to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section E, *How to contact the Quality Improvement Organization (QIO)*.

In Ohio, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

Member Grievance/Appeal Form | Ohio

Member Name | Member ID#

_____ _____

Member Address | Member Telephone

_____ _____

_____ _____

If the grievance/appeal concerns a provider(s), please supply the information, if known.

Name of Provider(s) _____

Address _____

Telephone _____

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

_____ _____

(Member Signature) (Date)

*If you are a representative that is filing a grievance or an appeal on behalf of a CareSource member, you must complete the Appointment of Representative form and submit the completed form with the Grievance/Appeal Form. The Appointment of Representative form can be found online here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

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**Request for Redetermination of Medicare Prescription Drug Denial**

Because we, CareSource® MyCare Ohio (Medicare-Medicaid Plan), denied your request for coverage of (or payment for) a prescription drug, you have the right to ask us for a redetermination (appeal) of our decision. You have 60 days from the date of our Notice of Denial of Medicare Prescription Drug Coverage to ask us for a redetermination. This form may be sent to us by mail or fax:

| Address: | Fax Number: |
|---|---|
| Express Scripts®<br>Attn: Medicare Appeals<br>P.O. Box 66588<br>St. Louis, MO 63166-6588 | **1-877-852-4070** |

You may also ask us for an appeal through our website at **CareSource.com/MyCare**. Expedited appeal requests can be made by phone at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

**Who May Make a Request:** Your prescriber may ask us for an appeal on your behalf. If you want another individual (such as a family member or friend) to request an appeal for you, that individual must be your representative. Contact us to learn how to name a representative.

**Enrollee's Information**

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Member ID Number _____

**Complete the following section ONLY if the person making this request is not the enrollee:**

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

**Representation documentation for appeal requests made by someone other than enrollee or the enrollee's prescriber:**

**Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan or 1-800-Medicare.**

**Prescription drug you are requesting:**

Name of drug: _____ Strength/quantity/dose: _____

Have you purchased the drug pending appeal? □ Yes □ No

If "Yes":

Date purchased: _____ Amount paid: $ _____ (attach copy of receipt)

Name and telephone number of pharmacy: _____

_____

**Prescriber's Information**

Name _____

Address _____

City _____ State _____ Zip Code _____

Office Phone _____ Fax _____

Office Contact Person _____

**Important Note: Expedited Decisions**

If you or your prescriber believes that waiting 7 days for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 7 days could seriously harm your health, we will automatically give you a decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking us to pay you back for a drug you already received.

□ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 72 HOURS**
**If you have a supporting statement from your prescriber, attach it to this request.**
**Please explain your reasons for appealing.** Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your prescriber and relevant medical records. You may want to refer to the explanation we provided in the Notice of Denial of Medicare Prescription Drug Coverage and have your prescriber address the Plan's coverage criteria, if available, as stated in the Plan's denial letter or in other Plan documents. Input from your prescriber will be needed to explain why you cannot meet the Plan's coverage criteria and/or why the drugs required by the Plan are not medically appropriate for you.

_____

_____

_____

**Signature of person requesting the appeal (the enrollee or the representative):**
**_____ Date: _____**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-475-3163 (TTY: 1-833-711-4711 o 711)**.

CareSource® MyCare Ohio (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

MyCareOhio
Connecting Medicare + Medicaid

CRP2005_003300.1 H8452_OHMYC-M-322005

# Chapter 10: Changing or ending your membership in our MyCare Ohio Plan

## Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan. If you leave our plan, you will still be in the Medicare and Ohio Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

## Table of Contents

## A. MyCare Ohio

You can end your membership in CareSource MyCare Ohio Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request.
- Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you ask to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.
- If you ask to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

You can get more information about when you can change or end your membership by calling:

- The Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**NOTE:** If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5, Section G, *Programs on drug safety and managing drugs* for information about drug management programs.

## B. How to change or end your membership in our plan

If you decide to change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1; **or**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 217.

Refer to Section A above for information on when your request to change or end your membership will take effect.

## C. How to join a different MyCare Ohio plan

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

To enroll in a different MyCare Ohio plan:

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

Your coverage with CareSource MyCare Ohio will end on the last day of the month that we get your request.

## D. How to get Medicare and Medicaid services

If you do not want to enroll in a different MyCare Ohio plan, you will return to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by CareSource MyCare Ohio.

### D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically stop getting Medicare services from our plan.

| **1. You can change to:**<br><br>**A Medicare health plan, such as a Medicare Advantage plan, which would include Medicare prescription drug coverage** | **Here is what to do:**<br><br>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.<br><br>If you need help or more information:<br><br>• Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.<br><br>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your new plan's coverage begins. |
|---|---|
| **2. You can change to:**<br><br>**Original Medicare with a separate Medicare prescription drug plan** | **Here is what to do:**<br><br>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can select a Part D plan at this time.<br><br>If you need help or more information:<br><br>• Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.<br><br>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your Original Medicare and prescription drug plan coverage begins. |

| 3. You can change to: | Here is what to do: |
|---|---|
| **Original Medicare without a separate Medicare prescription drug plan**<br><br>**NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join.<br><br>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call your Ohio Senior Health Insurance Information Program (OSHIIP) at 1-800-686-1578 (TTY: 711). | Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.<br><br>If you need help or more information:<br><br>• Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1.<br><br>You will automatically stop getting Medicare services through CareSource MyCare Ohio when your Original Medicare coverage begins. |

## D2. How to get your Medicaid services

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

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

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

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

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

## E. Keep getting your medical items, services and drugs through our plan until your membership ends

If you change or end your enrollment with CareSource MyCare Ohio, it will take time before your new coverage begins. During this time, keep getting your Medicare and Medicaid services through our plan.

- Use our network providers to receive medical care.
- **Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership in CareSource MyCare Ohio changes or ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

## F. Other situations when your membership ends

These are the cases when Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months or you establish primary residence outside of Ohio.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.

- The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

We can ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members.
- If you let someone else use your Member ID Card to get medical care.
  - If your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

## G. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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

## H. Your right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance or make a complaint about our request to end your membership. You can also refer to Chapter 9, Section J, *How to make a complaint* for information about how to make a complaint.

## I. How to get more information about ending your plan membership

If you have questions or would like more information on when Medicare and Medicaid can end your membership, you can call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, 8 a.m. – 8 p.m., Monday – Friday.

# Chapter 11: Definitions of important words

## Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

**Activities of daily living:** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

**Advance directive:** A legal document that you can use to give directions about your future health care in case you become unable to make health care decisions for yourself. Examples are a living will and a power of attorney for health care. (See Chapter 8, Section H, *Your right to make decisions about your health care*)

**Biological Product:** A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

**Biosimilar:** A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

**Care Manager:** A person who works with you, with CareSource MyCare Ohio, and with your care providers to make sure you get the care you need. (See Chapter 1, Section C, *Advantages of this plan*)

**Care Plan:** The plan for what health services you will get and how you will get them. Your Care Team will work with you to make and continuously update your care plan to address the health services you need and want. (See Chapter 1, Section G, *Your care plan*)

**Care Team:** Doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. The Care Team and Care Manager will work with you to come up with a care plan specifically designed to meet your needs. The Care Team will be in charge of coordinating the services you need. (See Chapter 1, Section C, *Advantages of this plan*)

**Community Well Member:** MyCare Ohio is a demonstration project that integrates Medicare and Medicaid benefits into one program. It is administered through a partnership between CMS and Ohio Medicaid. Eligible individuals include those in a nursing facility; individuals in some home and community-based settings and those individuals in the community not receiving LTSS who are dually eligible. This last group is referred to as “Community Well”. The Community Well category represents those Beneficiaries who do not meet the nursing facility level of care (NFLOC) standard.

**Covered services:** The general term we used to mean all of the health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment, and other services that our plan pays for. (See Chapter 3, Section A, *Information about “services,” “covered services,” “providers,” “network providers,” and “network pharmacies”*)

**Drug tiers:** Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three (3) tiers. (See Chapter 5, Section B, *The plan’s Drug List*)

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers. (See Chapter 3, Section L, *Durable medical equipment (DME)*)

**Explanation of Benefits (EOB):** A summary report that we send you when you use your MyCare benefits to verify the services or drugs you receive. The EOB for prescription drugs helps you understand and keep track of payments for your Part D drugs. It tells you the total amount we have paid for each of your Part D prescription drugs during the month. (See Chapter 1, Section J, *Other important information you will get from us*)

**Guardian:** A person appointed by a court to be legally responsible for another person. A court appoints a guardian to manage the personal affairs of an adult who can no longer make safe and sound decisions by themselves due to a legal or mental incapacity. A minor may also have a guardian appointed by a court in certain situations. Only a court may appoint a guardian. The court that usually appoints a guardian is your local probate court. It may be different depending upon where you live. Contact your local court, a local attorney, or local legal aid service for more information on guardianship. (See Chapter 2, Section B, *How to contact your Care Manager*)

**Health Care Power of Attorney (POA):** A Health Care Power of Attorney is a legal document that allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you cannot act for yourself. A Health Care POA is sometimes called a Durable Power of Attorney for Health Care. (See Chapter 8, Section H, *Your right to make decisions about your health care*)

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. An enrollee who has a terminal prognosis has the right to elect hospice. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. CareSource MyCare Ohio must give you a list of hospice providers in your geographic area. (See Chapter 4, Section D, *The Benefits Chart*)

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your CareSource MyCare Ohio Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your CareSource Member ID card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. (See Chapter 7, Section A, *Asking us to pay for your services or drugs*)

**List of Covered Drugs (Formulary or "Drug List"):** A list of prescription drugs that are covered by our plan. The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. (See Chapter 1, Section J, *Other important information you will get from us*)

**Long term support services (LTSS):** Sometimes referred to as waiver services, these include things such as home delivered meals, emergency response services and adult day care. These are services to help eligible members live independently. (See Chapter 3, Section E, *How to get long-term services and supports (LTSS)*)

**Medicaid:** Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules. (See Chapter 1, Section B, *Information about Medicare and Medicaid*)

**Medically necessary:** The services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. (See Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan*)

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure). (See Chapter 1, Section B, *Information about Medicare and Medicaid*)

**Medicare Advantage Plan:** A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-Medicaid plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and Care Teams to help you manage all your providers and services. They all work together to provide the care you need. (See Chapter 1, Section A, *Welcome to CareSource MyCare Ohio*)

**Member Services:** A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. (See Chapter 2, Section A, *How to contact CareSource MyCare Ohio Member Services*)

**Network pharmacies:** The pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use. Except in an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy. (See Chapter 1, Section J, *Other important information you will get from us*)

**Network providers:** Doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medicaid. Network providers have agreed to accept payment from our plan for covered services as payment in full. For a full list of network providers, see the *Provider and Pharmacy Directory*. (See Chapter 1, Section J, *Other important information you will get from us*)

**Original Medicare (traditional Medicare or fee-for-service Medicare):** Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

**Over-the-counter (OTC) Drugs:** Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional. (See Chapter 5, Section B, The plan's Drug List)

**Patient Liability:** This is the amount you must pay toward your long-term care services while living in a facility. (See Chapter 4, Section A, Your covered services)

**Personal health information (also called Protected health information) (PHI):** Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to CareSource MyCare Ohio's Notice of Privacy Practices for more information about how CareSource MyCare Ohio protects, uses, and discloses your PHI, as well as your rights with respect to your PHI. (See Chapter 1, Section K, How to keep your membership record up to date)

**Primary care provider (PCP):** Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. (See Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers*)

**Prior authorization:** Approval in advance to get certain services or drugs. Your provider must submit information to CareSource MyCare Ohio and request approval for you to receive the service. (See Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan*)

**Prosthetics and Orthotics:** These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy. (See Chapter 3, Section L, *Durable medical equipment (DME)*)

**Quality Improvement Organization (QIO):** This is a regional organization responsible for member appeals and quality-of-care reviews. (See Chapter 2, Section E, *How to contact the Quality Improvement Organization (QIO)*)

**Quantity limits:** A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription. (See Chapter 5, Section C, *Limits on some drugs*)

**Real Time Benefit Tool:** A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

**Service area:** The geographic area where our health plan accepts members based on where people live. The plan may disenroll you if you permanently move out of the plan's service area. (See Chapter 1, Section D, *CareSource MyCare Ohio's service area*)

**Specialist:** A doctor who provides health care for a specific disease or part of the body. For example, oncologists (care for patients with cancer) or cardiologists (care for patients with heart problems). (See Chapter 3, Section D, *Care from primary care providers, specialists, other network providers, and out-of-network providers*)

**Step therapy:** A rule that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed. This may apply to some of the drugs on our Drug List. (See Chapter 5, Section C, *Limits on some drugs*)

## CareSource MyCare Ohio Member Services

| | |
|---|---|
| **CALL** | **1-855-475-3163**<br>Calls to this number are free. 8 a.m. – 8 p.m., Monday - Friday<br>Member Services also has free language interpreter services available for non-English speakers. |
| **TTY** | **1-833-711-4711 or 711**<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. 8 a.m. – 8 p.m., Monday - Friday |
| **WRITE** | CareSource<br>P.O. Box 8738<br>Dayton, OH 45401-8738<br>Send appeals to:<br>CareSource MyCare Appeals<br>P.O. Box 1947<br>Dayton, OH 45401-1947 |
| **WEBSITE** | CareSource.com/MyCare |

CareSource

**English:** We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter, just call us at **1-855-475-3163** (TTY: 1-833-711-4711 or 711), 8 a.m. - 8 p.m., Monday – Friday. Someone who speaks your language can help you. This is a free service.

**Spanish:** Contamos con servicios gratuitos de intérprete para responder cualquier pregunta que pueda tener acerca de nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al **1-855-475-3163** (TTY: 1-833-711-4711 o 711), de 8 a. m. a 8 p. m., de lunes a viernes. Una persona que habla español puede brindarle ayuda. Este servicio es gratuito.

**Chinese Mandarin:** 我们提供免费口译服务，以回答您对我们的健康或药物计划的任何问题。 如要获取口译服务，请在周一至周五的上午 8:00 至晚上 8:00 致电 **1-855-475-3163** (聋哑人电传打字服务专线：1-833-711-4711 或 711) 联系我们。 届时，我们将安排会讲普通话的人员为您提供帮助。 此项服务免费提供。

**Chinese Cantonese:** 我們提供免費的口譯服務，以回答您可能對我們的健康或藥物計劃擁有的任何疑問。 如需口譯員，請致電 **1-855-475-3163** 聯絡我們（TTY 聽障電話專線：1-833-711-4711 或 711）；服務時間為： 週一至週五上午 8 點至晚上 8 點。 我們將安排會說繁體中文的人員為您提供幫助。 此項服務免費提供。

**Tagalog:** Mayroon kaming mga libreng serbisyo ng interpreter upang sagutin ang anumang mga katanungan na maaaring mayroon ka tungkol sa aming plano sa kalusugan o gamot. Upang makakuha ng interpreter, tawagan lang kami sa **1-855-475-3163** (TTY: 1-833-711-4711 o 711), 8 a.m. - 8 p.m., Lunes - Biyernes. Matutulungan ka ng isang taong nagsasalita ng Tagalog. Libreng serbisyo ito.

**French:** Des services d'interprétation vous sont proposés gratuitement pour répondre à toutes vos questions sur notre programme relatif à la santé ou aux médicaments. Pour obtenir un interprète, contactez-nous au **1-855-475-3163** (téléscripteur : 1-833-711-4711 ou 711) de 8 h 00 à 20 h, du lundi au vendredi. Une personne parlant français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có các dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào mà quý vị có thể có về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có thông dịch viên, chỉ cần gọi cho chúng tôi theo số **1-855-475-3163** (TTY: 1-833-711-4711 hoặc 711), 8 giờ sáng - 8 giờ tối, từ Thứ 2 đến Thứ 6. Một người nói Tiếng Việt có thể giúp quý vị. Dịch vụ này miễn phí.

**Russian:** Мы бесплатно предоставляем услуги устного перевода в случае, если у вас могут возникнуть вопросы о нашем медицинском или лекарственном плане. Для получения услуг устного перевода, просто позвоните нам по номеру **1-855-475-3163** (телетайп: 1-833-711-4711 или 711) с 8:00 до 20:00 с понедельника по пятницу. Вам может помочь человек, говорящий на русском языке. Эта услуга предоставляется вам бесплатно.

**Arabic:** لدينا خدمات المترجمين الفوريين للإجابة على أي أسئلة قد تكون لديك حول خطتنا الصحية أو الدوائية. للحصول على مترجم فوري، فقط اتصل بنا على **1-855-475-3163** (TTY: 1-833-711-4711 أو 711)، 8 صباحًا حتى 8 مساءً، من الإثنين إلى الجمعة. يمكن لشخص يتحدث اللغة العربية تقديم المساعدة لك. هذه الخدمة مجانية.

**Italian:** Disponiamo di servizi gratuiti di interpretariato per rispondere a qualsiasi domanda in merito al nostro piano sanitario o farmaceutico. Per richiedere un interprete è sufficiente chiamarci al numero **1-855-475-3163** (TTY: 1-833-711-4711 o 711), dalle 8.00 alle 20.00, dal lunedì al venerdì. Potrai ricevere assistenza da qualcuno che parla italiano come te. Il servizio è gratuito.

**Portuguese:** Oferecemos serviços de interpretação gratuitos para responder a quaisquer perguntas que possa ter sobre o nosso plano de saúde ou medicamentos. Para obter um intérprete, basta ligar para **1-855-475-3163** (Teletipo: 1-833-711-4711 ou 711), das 8:00 às 20:00, de segunda a sexta-feira. Alguém que fale [Português] pode ajudá-lo. Este serviço é gratuito.

**French Creole:** Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou kapab genyen sou plan sante oswa medikaman. Pou w jwenn yon entèprèt, jis rele nou nan **1-855-475-3163** (TTY: 1-833-711-4711 oswa 711), 8 a.m. - 8 p.m., Lendi – Vandredi. Yon moun ki pale kreyòl kapab ede w. Sa se yon sèvis gratis.

**Polish:** Oferujemy bezpłatne usługi tłumacza, który odpowie na wszelkie pytania dotyczące naszego planu opieki zdrowotnej lub planu leczenia farmakologicznego. W celu skorzystania z usług tłumacza prosimy o kontakt pod numerem **1-855-475-3163** (TTY (dalekopis): 1-833-711-4711 lub 711), od 8:00 do 20:00, od poniedziałku do piątku. Asystent mówiący po polsku udzieli Państwu pomocy. Usługa jest bezpłatna.

**German:** Bei Fragen zu unserem Gesundheits- oder Arzneimittelplan steht Ihnen ein kostenloser Dolmetscherdienst zur Verfügung. Um einen Dolmetscher in Anspruch zu nehmen, rufen Sie uns einfach montags bis freitags von 8.00 Uhr bis 20.00 Uhr unter **1-855-475-3163** (TTY: 1-833-711-4711 oder 711) an. Jemand, der Deutsch spricht, wird Ihnen weiterhelfen. Dieser Dienst ist kostenlos.

**Korean:** 건강 플랜이나 처방약 플랜에 대하여 궁금하신 점에 대해 답을 드릴 때 무료 통역 서비스를 이용하실 수 있습니다. 통역가가 필요하시면 **1-855-475-3163** (TTY: 1-833-711-4711 또는 711)으로 월요일부터 금요일까지 오전 8시부터 오후 8시 사이에 전화 주십시오. 한국어를 구사하는 담당자가 도와드릴 수 있습니다. 본 서비스는 무료로 제공됩니다.

**Hindi:** हमारी स्वास्थ्य या दवा योजना के बारे में आपके हो सकने वाले किसी भी प्रश्नों का उत्तर देने के लिए हमारे पास निःशुल्क दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए, बस हमें **1-855-475-3163** (TTY: 1-833-711-4711 या 711), 8 a.m. - 8 p.m., सोमवार - शुक्रवार, पर कॉल करें। हिंदी में बात करने वाला कोई व्यक्ति आपकी मदद कर सकता है। यह सेवा निःशुल्क है।

**Japanese:** 医療保険または医薬品プランに関するご質問にお答えするため、無料の通訳サービスがあります。 通訳をご希望の方は、**1-855-475-3163** (TTY: 1-833-711-4711 または 711) までお電話下さい。 月～金曜日、午前8時～午後8時にご利用いただけます。 日本語を話す通訳者が対応いたします。 こちらは無料サービスです。

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# Notice of Non-Discrimination

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of age, gender, gender identity, color, race, disability, national origin, ethnicity, marital status, sexual preference, sexual orientation, religious affiliation, health status, or public assistance status. CareSource offers free aids and services to people with disabilities or those whose primary language is not English. We can get sign language interpreters or interpreters in other languages so they can communicate effectively with us or their providers. Printed materials are also available in large print, braille or audio at no charge. Please call Member Services at the number on your CareSource ID card if you need any of these services. If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

Mail: CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947
Dayton, Ohio 45401

Email: CivilRightsCoordinator@CareSource.com
Phone: 1-800-488-0134 (TTY: 711)
Fax: 1-844-417-6254

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

Mail: U.S. Dept of Health and Human Services
200 Independence Ave, SW Room 509F HHH Building
Washington, D.C. 20201

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf

Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

Complaint forms are found at: http://www.hhs.gov/ocr/office/file/index.html.

MyCareOhio
*Connecting Medicare + Medicaid*

CareSource®

**Member Services**

**1-855-475-3163**

**(TTY: 1-833-711-4711 or 711)**

8 a.m. to 8 p.m., Monday through Friday

**CareSource.com/MyCare**


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