CareSource®
MyCare Ohio
(Medicare - Medicaid Plan)

2025 MEDICAID-ONLY Member Handbook

CareSource®

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

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

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. إذا كنت من ذوي الاحتياجات الخاصة، ستحصل على المساعدات والدعم مجانًا. اتصل على الرقم **1-855-475-3163 (TTY "الهاتف النصيّ للصم وضعاف السمع":** **1-833-711-4711 او 711).**

通过口译员和其他书面材料，获得您所使用语言的免费帮助。 如果您有残疾，可以获得免费的辅助设备和支持。 请致电：**1-855-475-3163（TTY 专线：1-833-711-4711 或 711）。**

Erhalten Sie kostenlose Hilfe in Ihrer Sprache durch Dolmetscher und andere schriftliche Unterlagen. Beziehen Sie kostenlose Hilfsmittel und Unterstützung, wenn Sie eine Behinderung haben. Rufen Sie **1-855-475-3163 (TTY: 1-833-711-4711 oder 711)**.

Obtenez une aide gratuite dans votre langue grâce à des interprètes et à d'autres documents écrits. Si vous souffrez d'un handicap, vous bénéficiez d'aides et d'assistance gratuites. Appelez le **1-855-475-3163 (TTY: 1-833-711-4711 ou le 711)**.

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

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आपकी भाषा के इंटरप्रेटर तथा आपकी भाषा में अन्य लिखित सामग्रियों संबंधी फ्री मदद पाएं। यदि आपको कोई डिसएबिलिटी हो, तो मुफ्त सहायता और सपोर्ट प्राप्त करें। कॉल करें **1-855-475-3163 (TTY: 1-833-711-4711 या 711)**.

통역사와 기타 서면 자료의 도움을 귀하의 언어로 무료로 받으세요. 장애가 있을 경우, 보조와 지원을 무료로 받으세요. **1-855-475-3163 (TTY: 1-833-711-4711 또는 711)** 로 문의하세요.

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Gba ìrànlọ́wọ́ ọ̀fẹ́ ní èdè rẹ pẹ̀lú àwọn ògbifọ̀ àti àwọn ohun èlò míràn tí a ko sílẹ̀. Gba àwọn ìrànlọ́wọ́ àti àtìlẹ́yìn ọ̀fẹ́ bí o bá ní àìlera kan. Pè **1-855-475-3163 (TTY: 1-833-711-4711 tàbí 711)**.

Makakuha ng libreng tulong sa wika mo gamit ang mga interpreter at mga ibang nakasulat na materyales. Makakuha ng mga libreng pantulong at suporta kung may kapansanan ka. Tumawag sa **1-855-475-3163 (TTY: 1-833-711-4711 o 711)**.

په خپله ژبه کې د ژباړونکو او نورو لیکلي شوو موادو له لاري وړیا مرسته ترلاسه کړئ. که تاسو معلولیت لرئ نو وړیا ملاتړ او مرستې ترلاسه کړئ. دې شمېرې ته زنګ ووهئ **1-855-475-3163 (TTY: 1-833-711-4711 یا 711).**

వ్యాఖ్యాతలు మరియు ఇతర రాతపూర్వక మెటీరియల్స్‌తో మీ భాషలో ఉచిత సహాయాన్ని పొందండి. ఒకవేళ మీకు వైకల్యం ఉంటే, ఉచిత ఉపకరణాలు మరియు మద్దతు పొందండి. కాల్ చేయండి: **1-855-475-3163 (TTY: 1-833-711-4711 లేదా 711)**.

दोभाषे र अन्य लिखित सामग्रीहरूको माध्यमद्वारा आफ्नो भाषामा निःशुल्क मद्दत प्राप्त गर्नुहोस्। तपाईंलाई अशक्तता छ भने निःशुल्क सहायता र समर्थन प्राप्त गर्नुहोस्। **1-855-475-3163 (TTY: 1-833-711-4711 वा 711)** मा कल गर्नुहोस्।

သင့်ဘာသာစကားအတွက် စကားပြန်များနှင့် အခြားပုံနှိပ်စာရွက်များကို အခမဲ့အကူအညီရယူပါ။ သင်သည် မသန်စွမ်းသူတစ်ဦးဖြစ်ပါက အခမဲ့အကူအညီများနှင့် အထောက်အပံ့များ ရယူပါ။ ဖုန်းခေါ်ရန် - **1-855-475-3163 (TTY: 1-833-711-4711 သို့မဟုတ် 711)**

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

Bōk jibañ ilo an ejjelok wōnāān ikkijjien kajin eo am ibbān rukok ro im wāween ko jet ilo jeje. Bōk jerbalin jibañ ko ilo an ejjelok wōnāer im jibañ ko ñe ewōr am nañinmejin utamwe. Kalle **1-855-475-3163 (TTY: 1-833-711-4711 ak 711)**.

Non-Discrimination Notice

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

We offer free aids, services, and reasonable modifications if you have a disability. We can get a sign language interpreter. This helps you talk with us or to your providers. Get your printed materials in large print, audio, or braille at no cost. We can also help if you speak a language other than English. We can get an interpreter who speaks your language. Or get printed materials in your language. You can get this all at no cost to you.

Call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)** if you need any of this help. We are open Monday through Friday, 8 a.m. to 8 p.m. We are here for you.

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

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

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

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

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

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

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QUICK REFERENCE

Care Management	**1-855-475-3163** (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. **1-866-206-7861** (TTY: 711) After hours
Your Care Manager:	_____ (add their name and phone number here)
Member Services	**1-855-475-3163 (TTY: 1-833-711-4711 or 711)** Monday through Friday, 8 a.m. to 8 p.m.
CareSource24 Nurse Advice Line	**1-866-206-7861 (TTY: 1-833-711-4711 or 711)** 24 hours a day, 7 days a week
Behavioral Health Line	**1-866-206-7861 (TTY: 1-833-711-4711 or 711)** 24 hours a day, 7 days a week
CareSource Pharmacist Helpline	**1-833-230-2073 (TTY: 711)** Monday through Friday, 8 a.m. to 5 p.m.

ATTENTION: If you do not speak English, language services, free of charge, are available to you. Call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m. The call is free.

ATENCIÓN: Si no habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-475-3163 (TTY: 1-833-711-4711 o 711)**, el lunes a viernes, 8 a.m. a 8 p.m. La llamada es gratuida.

If you have any problem reading or understanding this information or any other CareSource MyCare Ohio information, please contact Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m. for help at no cost to you. We can explain this information in English or in your primary language. 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)**, Monday – Friday, 8 a.m. – 8 p.m. The call is free.

Please read this handbook from cover to cover. It will answer many of the questions you might have about your CareSource MyCare Ohio Medicaid benefits. Or you can visit our website at **CareSource.com/MyCare**. Please note that this handbook does not cover your Medicare benefits.

MyCareOhio
Connecting Medicare + Medicaid

WELCOME

Welcome to CareSource® MyCare Ohio (Medicare-Medicaid Plan). You are now a member of a MyCare Ohio health care plan, also known as a MyCare Ohio managed care plan (MCOP). An MCOP is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, 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 provides health care services to Ohio residents who are eligible.

CareSource MyCare Ohio is only managing your Medicaid benefits right now.

We can manage both your Medicare and Medicaid benefits through the MyCare Ohio plan at no cost to you. To make this change, please call the Ohio Medicaid Consumer Hotline at 1-800-324-8680 (TTY: 711). They are open Monday through Friday, 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m.

Choosing CareSource MyCare Ohio for your Medicare and Medicaid benefits means that you will get:

- **No copays** for your Medicare or Medicaid benefits.
- **No copays** for prescription drugs.
- A HealthyBenefits+™ card with:
  - A **$100** over-the-counter (OTC) allowance **four times** each year for vitamins, first aid supplies and more.
  - A **$500** flex allowance each year for dental, vision and hearing services and accessories beyond what the plan already covers.
- My CareSource Rewards Program® with a chance to earn up to **$365** for completing healthy activities.
- 60 one-way rides to you at no cost. You can go to health care visits, the pharmacy, the grocery or to the gym.
- One plan and one ID card.
- Coordinated Medicare and Medicaid benefits.

If you ever have a question or need to contact CareSource MyCare Ohio, please call us at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**. Please let us know if you ever have a question or concern about your health care or our services.

Who is Eligible to Enroll in a MyCare Ohio Plan?

You are eligible for membership in our MyCare Ohio plan as long as you:

- Live in our service area; **and**
- Have Medicare Parts A, B and D; **and**
- Have full Medicaid coverage; **and**
- Are 18 years of age or older at the time of enrollment.

You are not eligible to enroll in a MyCare Ohio managed care plan if you:

- Do not have full Medicaid benefits and Medicare Parts A, B and D;
- Are younger than age 18;
- Have any private creditable medical insurance, including retiree benefits, other than a Medicare Advantage plan; or
- Have intellectual or other developmental disabilities and receive services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID); or
- Are enrolled in PACE (Program for All-Inclusive Care for the Elderly).

Additionally, you have the option not to be a member of a MyCare Ohio managed care plan if:

- you are a member of a federally recognized Indian tribe, regardless of your age.
- you are an individual who receives home and community-based waiver services through the Ohio Department of Developmental Disabilities.

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

CareSource MyCare Ohio is available only to people who live in our service area. Our service area includes the following counties:

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

If you move to an area outside of our service area, you cannot stay in this plan. If you move, please report the move to your County Department of Job and Family Services office and to CareSource MyCare Ohio.

New Member Information

This handbook tells you about your coverage under CareSource MyCare Ohio. It explains how to receive health care services, behavioral health coverage, prescription drug coverage, home and community-based waiver services, also called long-term care services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. You will also find additional information such as: providers that you can use to receive care (also known as network providers), member rights, additional benefits, and steps you can take if you are unhappy or disagree with something.

You can request a printed provider directory by calling the Member Services Department or by returning the postcard you received with your new member letter and member identification (ID) card. You can also request a printed directory by filling out an online form at **CareSource.com/oh/plans/mycare/plan-documents/**. The provider directory lists all of our panel providers as well as other non-panel providers you can use to receive services. You can also visit our website at **CareSource.com/MyCare** to view up to date provider panel information or call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m. for assistance.

Panel providers are MCOP's contracted providers available to the MCOP's general membership. Non-panel providers are non-contracted providers available to the MCOP's general membership.

While CareSource MyCare Ohio is approved by the state and federal governments to provide both Medicare and Medicaid-covered services, you chose or were assigned to receive only your Medicaid-covered services from our plan. If you want to receive both your Medicare and Medicaid-covered services from your MyCare Ohio MCOP, see **page 53** for more information.

Network Providers

It is important to understand that members must receive Medicaid services from facilities and/or providers in CareSource MyCare Ohio's provider network. A network provider is a provider who works with our health plan and has agreed to accept our payment as payment in full. Network providers include but are not limited to: nursing facilities, home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicaid. The only time you can use providers that are not in network is for services that Medicare pays for OR an out-of-network provider of Medicaid services that CareSource MyCare Ohio has approved you to see during or after your transition of care period.

For a specified time period after your enrollment in the MyCare Ohio program, we may allow you to receive care from a provider that is not a CareSource MyCare Ohio panel provider (out-of-network provider). Additionally, we may allow you to continue to receive 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 an out-of-network provider does not start over. The *New Member Letter*, enclosed with this handbook, has more information on transition time periods, services and providers. If you are currently seeing a provider that is not in our network or if you already have services approved or scheduled, it is important that you call Member Services immediately (today or as soon as possible) so CareSource MyCare Ohio can arrange the services and avoid any billing issues.

You can find out which providers are in our network by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)** or on our website at **CareSource.com/MyCare**. You can also contact the Medicaid Hotline at 1-800-324-8680, TTY users should call Ohio Relay at 7-1-1, or on the Medicaid Hotline website at **www.ohiomh.com**. You can request a printed Provider and Pharmacy Directory at any time by calling Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

CARE MANAGEMENT

CareSource MyCare Ohio offers care management services to all members. When you first join our plan, you will receive a health care needs assessment within the first 15 to 75 days of your enrollment effective date, depending on your health status. You will be contacted by your care manager, or a member of the care management team, to schedule a date to complete the first assessment. It will be completed by your Care Manager or Care Manager delegate and family care givers and other supports per your preference. It can be done at your home or a location of your choice, including at a provider's office or hospital.

CareSource MyCare Ohio Care Managers are Registered Nurses, Licensed Social Workers and Licensed Independent Social Workers. They coordinate 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. CareSource delegates care management and Waiver service coordination to the Area Agencies on Aging and works with them to make sure your needs are met.

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

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

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

- Legal guardians
- Authorized representatives
- External community agency staff

Your Care Team works together to make sure your care is coordinated. This means that they make sure that tests and lab work are done once, and the results shared with the right providers. It also means that your doctors know all of the medications you are taking so they can reduce any negative effects. Your doctors will always have your permission before sharing your medical information with other providers. Your Care Team may ask questions to learn more about your health. The team will give you information to help you to understand how to care for yourself and how to get services, including local resources. The team can also work with you if you need help figuring out where to get care, whether from your primary care provider (PCP) or going to urgent care or the ER.

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

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

Please call us if you have any questions or feel that you would benefit from care management. We are happy to help. All members, including those who receive long-term care and/or waiver services, can access a care team representative 24/7. Just call **1-855-475-3163 (TTY: 1-833-711-4711 or 711)** 8 a.m. to 8 p.m. Monday through Friday. After hours, call **1-866-206-7861**.

IDENTIFICATION (ID) CARDS

You should have received a CareSource MyCare Ohio member ID card. Each member of your family who has joined CareSource MyCare Ohio will receive their own card. These cards replace your Medicaid card. Each card is good for as long as the person is a member of CareSource MyCare Ohio. You will receive your card after enrollment. It is important to note that this card will only work for Medicaid- covered services. Any medical services covered by Medicare or a selected Medicare Advantage plan will require a different card for those benefits If you have a separate Medicare Part D plan, please provide your Part D card to your pharmacy for prescription drugs.

Always Keep Your ID Card(s) With You

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

- See your primary care provider (PCP)
- See a specialist or other provider
- Go to an emergency room
- Go to an urgent care facility
- Go to a hospital for any reason
- Go to a pharmacy
- Go to labs or imaging providers
- Go to nursing facilities
- Receive waiver service or start with a new waiver provider
- Get medical supplies
- Get a prescription
- Have medical tests
- See a dental provider
- Get vision care

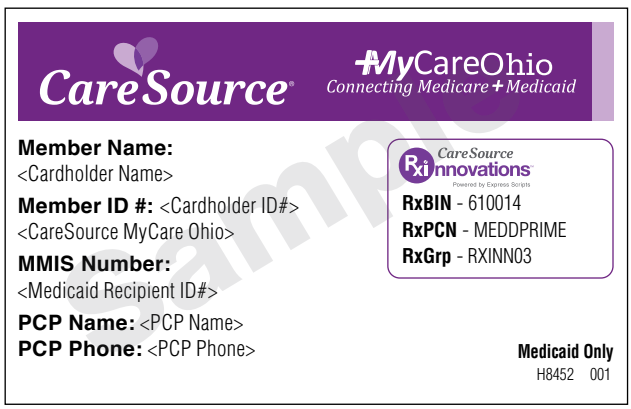
Call CareSource MyCare Ohio Member Services as soon as possible at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)** if:

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

If you have a baby, please remember to contact your local county Job and Family Services office.

You will get a new ID card if you ask for a replacement or if you change your primary care provider (PCP).

FRONT OF ID CARD


CareSource
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Member Name:
<Cardholder Name>

Member ID #: <Cardholder ID#>
<CareSource MyCare Ohio>

MMIS Number:
<Medicaid Recipient ID#>

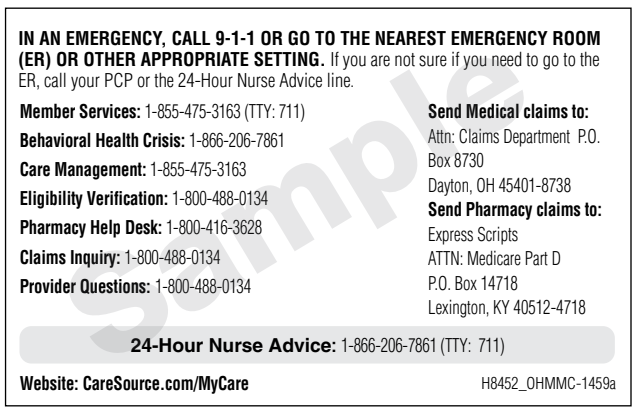
PCP Name: <PCP Name>
PCP Phone: <PCP Phone>

CareSource Rxinnovations
Powered by Express Scripts
RxBIN - 610014
RxPCN - MEDDPRIME
RxGrp - RXINN03

Medicaid Only
H8452 001

Sample

BACK OF ID CARD


IN AN EMERGENCY, CALL 9-1-1 OR GO TO THE NEAREST EMERGENCY ROOM (ER) OR OTHER APPROPRIATE SETTING. If you are not sure if you need to go to the ER, call your PCP or the 24-Hour Nurse Advice line.

Member Services: 1-855-475-3163 (TTY: 711)
Behavioral Health Crisis: 1-866-206-7861
Care Management: 1-855-475-3163
Eligibility Verification: 1-800-488-0134
Pharmacy Help Desk: 1-800-416-3628
Claims Inquiry: 1-800-488-0134
Provider Questions: 1-800-488-0134

Send Medical claims to:
Attn: Claims Department P.O. Box 8730
Dayton, OH 45401-8738

Send Pharmacy claims to:
Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

24-Hour Nurse Advice: 1-866-206-7861 (TTY: 711)

Website: CareSource.com/MyCare
H8452_OHMMC-1459a

Sample

CONTACT US

Member Services

	Phone	**1-855-475-3163 (TTY: 1-833-711-4711 or 711)** Open Monday through Friday, 8 a.m. to 8 p.m.
	Mailing Address:	P.O. Box 8738 Dayton, OH 45401-8738
	Online:	**CareSource.com/MyCare**

Member Services can help you:

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

Let Member Services know if:

- ✓ Your address, phone number or email changes. You need to also change this through your County Department of Job and Family Services.
- ✓ Your designated responsible party or caregiver changes
- ✓ You have health insurance coverage other than Medicare.
- ✓ You are admitted to a nursing home or hospital.
- ✓ You get care in an out-of-area or out-of-network hospital or emergency room.
- ✓ You are pregnant.

Have your CareSource member ID number handy when you call. This will help us serve you faster.

If you call after hours, on a weekend or holiday, you may leave a message and we will respond within one business day. You can also reach us online at any time. Visit **secureforms.CareSource.com/en/MemberInquiry/oh**.

We are closed* in 2025 on these days:

- January 1
- January 13
- May 26
- July 4
- September 1
- November 27 and 28
- December 24 and 25

*Our CareSource24® Nurse Advice Line is open 24/7, 365 days a year.

Accommodations and Interpreter Services

Are you or someone you care for a CareSource member who:

- Does not speak English?
- Has hearing or vision problems?
- Has trouble reading or speaking English?

We can help. We can get you interpreters for sign language or in the language you speak. Interpreters can help you talk with us or your providers. You can also get materials in other formats like large print, braille, or audio.

CareSource24 Nurse Advice Line

Phone **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**
Open 24 hours a day, 7 days a week, 365 days a year

CareSource24® can help you:

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

My CareSource

My CareSource® is a secure account. It uses multi-factor authentication to keep your data safe. Here are a few things you can do in this account:

- Choose or change your primary care provider (PCP).
- View your digital ID card.
- Order a new ID card if you lost it. We will send you a new one in the mail.
- View your claims and plan records.
- View health alerts and more!

Signing up is easy:

1. Go to **MyCareSource.com**.
2. Click ***Sign Up*** at the bottom of the page.
3. Answer the questions.
4. Click ***Register***. You're all set!

Words to Know

Multi-Factor Authentication – Using more than just a password to log in to an account. There are three main methods used:

1. What you know: a password or PIN.
2. What you have: a badge or entering a code from your phone.
3. What you are: a fingerprint or using your voice.

SERVICES COVERED BY CARESOURCE MYCARE OHIO

Medicaid helps with medical costs for certain people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and may also pay for Medicare deductibles, coinsurance and copayments 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. Because you chose or were assigned to only receive Medicaid-covered services from our plan, Medicare will be the primary payer for most services. You can choose to receive both your Medicare and Medicaid benefits through CareSource MyCare Ohio so all of your services can be coordinated. Please see **page 53** for more information on how you can make this choice.

As a CareSource MyCare Ohio member, you will continue to receive all medically necessary Medicaid- covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. You should not be billed for these services. If you receive a bill, please call Member Services.

Words to Know

Covered Service – medically necessary care that we pay for.

Medically Necessary – care that is needed to diagnose or treat an illness, injury, condition, disease or its symptoms.

Prior Authorization – approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you.

Referral – an order from your provider for you to see a specialist or get certain health care.

Services covered by CareSource are listed in the covered services chart on **page 12**.

Prior Authorization and Referrals

Some services need to be approved by us before you can get them. **Prior authorization** is the approval that may be needed before you get a service. It must be medically necessary for your care. Your network provider will get prior authorization for the care you need. Network or in-network means that these providers see CareSource members.

Services that need prior authorization are noted in the covered services chart on **page 12**. You can also call Member Services to learn more.

Referral means that your provider will request these services for you before you can get them. Your provider will either call and arrange these services for you, give you a written note to take with you, or tell you what to do.

Covered Services Chart

SERVICE	MORE INFORMATION	REQUIREMENTS
Acupuncture	Acupuncture for pain management of migraine headaches and lower back pain is covered.	No prior authorization is needed.
Ambulance and Wheelchair Van Transportation	Taking an ambulance or a wheelchair van is covered for emergencies.	Non-emergency ambulance services need prior authorization.
Behavioral Health Services (including mental health and substance use disorder treatment)	Mental health and substance use disorder treatment services are available. These services include: • Diagnostic evaluation and assessment • Psychological testing • Psychotherapy and counseling • Crisis intervention • Mental health services including therapeutic behavioral service, psychosocial rehabilitation, community psychiatric supportive treatment, assertive community treatment for adults, and intensive home-based treatment for children/adolescents • Substance use disorder treatment services including case management, peer recovery support, intensive outpatient, partial hospitalization, residential treatment, and withdrawal management • Medication-assisted treatment for addiction • Opioid treatment program services • Medical services • Behavioral health nursing services If you need help right away, call or text 988. You can self-refer to an Ohio Department of Mental Health and Addiction Services (Ohio MHAS) certified community behavioral health center or qualified behavioral health provider. You can find network providers in your provider directory or at **FindADoctor.CareSource.com**. You can also call Member Services to learn more. If you need help for Substance Use Disorder treatment call the CareSource Addiction Support Line at **1-833-674-6437** (TTY: 711).	Prior Authorization is needed for the following services: • All inpatient services • Assertive Community Treatment (ACT) for Adults • Intensive Home-Based Treatment (IHBT) • Partial Hospitalization Program (PHP) services • Substance Use Disorder (SUD) Residential: PA needed after 30-days for the first two admissions in a calendar year and initially for a third admission in a calendar year.) • Transcranial Magnetic Stimulation (TMS)

SERVICE	MORE INFORMATION	REQUIREMENTS
Certified Nurse Midwife (CNM) Services	Nurses who help you with pregnancy, labor and giving birth. Find a CNM in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	No prior authorization is needed. You may self-refer for these services.
Certified Nurse Practitioner (CNP) Services	Nurses who are trained in some of the medical care that doctors provide. Find a CNP in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	No prior authorization is needed. You may self-refer for these services.
Chiropractic Services	Involves adjustments to the spine or other parts of the body. Find a chiropractor in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	No prior authorization is needed.
Dental Services	One dental exam and cleaning is covered every 6 months for those age 20 and under. One dental exam and cleaning each year for those age 21 and older. Find a dentist in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	These services need a prior authorization: • Some CT scans • Crowns, post and core procedures • Dentures/Partials • Oral Surgery Procedures • Periodontal Services • Orthodontics/dental braces (Must be under age 21) Please check with your provider about what is needed for dental services.
Diagnostic Services	Lab work, x-rays or tests done to learn more about a specific condition or disease.	These services need a prior authorization (including but not limited to): • Some bloodwork/lab testing • Scans (CT, MRI, PET)

SERVICE	MORE INFORMATION	REQUIREMENTS
Durable Medical Equipment (DME) and Supplies	Medical equipment and supplies that can be used more than once for health services. Examples of DME are orthotics, walking aids, blood pressure machines and more. Please call Member Services to learn more. Orthotics can be replaced once each year when medically necessary. More replacements may be allowed if there is damage that cannot be repaired or if you are under the age of 18 and have outgrown your equipment. This excludes repair/replacement if it was lost or stolen, misused, was broken maliciously or from gross neglect.	Prior authorization is needed for (including but not limited to): • Wheelchairs and some accessories • All rental/lease items like: CPAP/ BiPAP, NPPV machines, apnea monitors, ventilators, hospital beds, specialty mattresses, high frequency chest wall oscillators, cough assist/stimulating device, pneumatic compression devices, speech generating devices and accessories, and infusion pumps • Cochlear implants including most replacements. • Left Ventricular Assist Device (LVAD) • Wound pump • Wound Vacs • Prosthetic/orthotic devices* • Oral appliances for obstructive sleep apnea • Patient transfer systems /hoyer lifts • Power wheelchair repairs • Spinal cord stimulators • Tumor treatment field therapy
Emergency Services	An emergency is a medical problem that must be treated right away. Emergency services are always covered. Learn more on **page 29**.	Emergency services do not need prior authorization. Call 911 or go to the nearest ER.
Family Planning Services and Supplies	Family planning includes things like birth control, family planning exams, nurse midwife services, and prenatal and postnatal doctor and home visits. You can get services from your PCP or any OB/GYN or Qualified Family Planning Provider (QFPP) like Planned Parenthood. You may self-refer for these services.	Infertility diagnostic services need prior authorization.

SERVICE	MORE INFORMATION	REQUIREMENTS
Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Services	FQHCs and RHCs help people who live in rural or urban areas get care. Covered care includes office visits for primary care and specialists services, physical therapy, speech pathology and audiology services, dental services, podiatry services, vision services, chiropractic services, and mental health services. Find a FQHC or RHC in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	No prior authorization is needed.
Free-standing Birth Center Services	Services at a free-standing birth center are covered. Call Member Services for help finding a center or go to **FindADoctor.CareSource.com**.	No prior authorization is needed.
Gynecological Services (OB/GYN)	OB/GYNs care for the female reproductive organs. You can get services from your PCP or any OB/GYN or family planning provider. You may self-refer for these services.	No prior authorization is needed for routine OB/GYN services.
Home and Community-Based Waiver Services	MyCare Ohio Waiver services are designed to meet the needs of members 18 years or older, 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 are enrolled in a waiver, please see your *MyCare Ohio Home & Community-Based Services Waiver Member Handbook* for waiver services information.	All Waiver services need prior authorization. You must be enrolled in care management.
Home Health Services	Home health care is a wide range of health care services that can be given in your home for an illness or injury.	Prior authorization is needed for: • Home Health aide visits • Private duty nursing (PDN) • Skilled nurse visits • Social worker visits • Occupational Therapy • Speech Therapy • Physical Therapy
Inpatient Hospital Services	Procedures or tests done in a hospital or medical center. They usually need an overnight stay.	All inpatient hospital services need prior authorization.

SERVICE	MORE INFORMATION	REQUIREMENTS
Maternity Care	Prenatal and postpartum, including at-risk pregnancy services and gynecological care is covered. You can get services from your PCP or any OB/GYN or family planning provider. You may self-refer for these services.	Prior authorization is needed if the delivery and inpatient stay is scheduled at less than 39 weeks. It is also needed if the stay is more than 48 hours for vaginal or 96 hours for cesarean delivery.
Medical Nutrition Supplies	Covered care includes diabetic and nutritional supplies. Diabetic supplies are limited to the following manufacturers: • Preferred test strips: Abbott/Lifescan • Preferred Continuous Glucose Monitors (CGM): Abbott Freestyle and Dexcom	Prior authorization is needed for: • Continuous glucose monitors • Donor milk • Insulin infusion device • Oral nutrition (for medical purposes) and enteral nutritional therapy.
Nursing Facility/Long Term Care Services and Supports	If you need these services, please call Member Services for information on available providers. The Office of the State Long-Term Care Ombudsman helps people get information about long-term care services in nursing homes and in your home or community and resolve problems between providers and members or their families. They can also help you file a complaint or an appeal with our plan. For MyCare Ohio members, help with concerns about any aspect of care is available through the MyCare Ohio Ombudsman. You can call 1-800-282-1206, Monday through Friday, 8 a.m. to 5 p.m. Calls to this number are free. You can submit an online complaint at aging.ohio.gov/contact/ or you can send a letter to: Ohio Department of Aging: MyCare Ohio Ombudsman 50 W. Broad St./ 9th Floor Columbus, OH 43215-3363	Nursing facility services need prior authorization. A level of care determination is required for custodial or intermediate care.
Outpatient Hospital Services*	Procedures or tests that can be done in a medical center without an overnight stay.	Elective surgeries need prior authorization.

SERVICE	MORE INFORMATION	REQUIREMENTS
Out-of-Network Providers	A doctor, hospital, drugstore or other licensed provider that has not signed a contract agreeing to give services to CareSource members. CareSource will not pay for services from these providers unless it is an emergency or we have given prior authorization. Find providers in the CareSource network at **FindADoctor.CareSource.com** or by calling Member Services.	Prior authorization is needed for out-of-network providers or services.
Podiatry (Foot) Services	Services for your feet.	No prior authorization is needed.
Prescription Drugs (certain drugs not covered by Medicare Part D)	All medically necessary Medicaid-covered medications are covered. We maintain a list of Medicaid-covered medications. We call these medications Additional Demonstration Drugs (ADD). Find this list of drugs at **CareSource.com/oh/plans/mycare/plan-documents/** Providers will write prescriptions for you that can be filled at a network pharmacy. Most prescriptions will be covered by your Medicare Part D provider. Please see **page 33** to learn more.	Prior authorization varies by drug. Please see **page 33** to learn more.
Preventive Breast Cancer and Cervical Cancer Screenings	Screenings for breast cancer (mammograms) and cervical cancer (pap tests) are covered.	No prior authorization is needed.
Preventive Prostate Screening	Screenings for prostate cancer for men are covered.	No prior authorization is needed.
Primary Care Provider (PCP) Services	You will get most of your preventive care from your PCP. They will do your checkups, shots and treat you for most of your routine health care needs. Your PCP will refer you to specialists or admit you to the hospital, if needed.	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
Renal Dialysis (kidney disease)	Dialysis is a procedure where toxins and extra fluids are filtered out of your blood. It is a covered service.	Prior authorization is needed for dialysis.
Residential Treatment	Places where you get therapy for substance use disorder, mental illness, or other behavioral problems.	Prior authorization is needed for residential treatment.
Respite Services	Care for people who are elderly or who have a disability so that their caregivers can have some time off. Respite is covered for caregivers of those under 21 years old that have long term care or behavioral health needs and qualify for Supplemental Security Income.	Prior authorization is required for respite services.
Shots (Immunizations)	Your PCP will do your checkups, shots and treat you for most of your routine health care needs.	No prior authorization is needed.
Specialist Services	A shot or immunization helps keep you from getting sick. Some shots protect you for years from diseases. Others are needed every year, like the flu shot. Work with your provider or pharmacist to get your shots at the right time.	Specialists or services outside of the CareSource network need prior authorization.
Speech and Hearing Services (including hearing aids)	Please contact Member Services for details.	These services need a prior authorization (including but not limited to): • Speech therapy • Hearing aids
Telehealth	Visit with a provider by phone or computer from wherever you are. You can use telehealth for many illnesses and injuries, common health issues, follow-up visits, screenings, and for prescribing medicine. Your PCP may offer telehealth. Contact their office to find out. You can also visit with a medical or behavioral health provider through Teladoc® at no cost to you. Call 1-800-835-2362 or visit Teladoc.com/MyCareOhio to get started.	No prior authorization is needed.

SERVICE	MORE INFORMATION	REQUIREMENTS
Tobacco Cessation Services	Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation are covered. Call the Ohio Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669). They are open 24 hours a day, 7 days a week including holidays. Interpreters are available if you do not speak English.	No prior authorization is needed.
Urgent Care Centers	Urgent Care Centers are for non-emergencies. They are for when you can't see your PCP right away. They help keep an injury, sickness or mental health issue from getting worse.	No prior authorization is required.
Vision Care (optical) services (including eyeglasses)	Includes eye exams, routine checkups, vision surgery and services from an eye doctor. • One comprehensive exam each year. Eyeglasses and contacts are covered: • 18–20 years old: one pair each year • 21–59 years old: one pair every two years • 60 years and older: one pair each year Deluxe frames, transitions and progressive lenses are not covered. Your vision benefits are covered by Superior Vision®. Find eye care at **FindADoctor.CareSource.com** or by calling Member Services. Make sure the provider knows you are covered by Superior Vision before you visit	Providers or services outside of the CareSource network need prior authorization.
Well-adult Exams	A yearly well-adult exam is a checkup with a provider to go over your medical history and check your health and fitness. This is covered at one visit each year.	No prior authorization is needed.
Well-child (Healthchek) Exams for children under the age of 21	Healthchek covers medical exams, immunizations (shots), health education and lab tests for those under the age of 21. Healthchek also covers medical, vision, dental, hearing, nutritional, developmental and behavioral health exams. See **page 31** to learn more.	No prior authorization is needed.

Services Not Covered by CareSource MyCare Ohio

CareSource MyCare Ohio will not pay for services or supplies received that are not covered by Medicaid. If you have a question about whether a service is covered, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m.

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

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

Services Not Covered by CareSource MyCare Ohio Unless Medically Necessary

CareSource MyCare Ohio will review applicable OAC rules (e.g. 5160-1-61) and conduct a medical necessity review if appropriate. If you have a question about whether a service is covered, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m.

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

- Abortions except in the case of a reported rape, incest or to save the life of the mother.
- Biofeedback services
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice.
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered.)
- Plastic or cosmetic surgery
- Services for the treatment of obesity
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.

Frequency Limitations

Your MyCare plan will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, Monday – Friday, 8 a.m. – 8 p.m.

BENEFITS

At CareSource, we care about you. We know that there is more to health and well-being than just great health care. That's why we offer benefits and services that go beyond basic care.

Mental Health

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

Need Help Now?

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

CareSource Behavioral Health Line

Speak to a licensed professional who has behavioral health training. Call **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. We are here for you 24/7.

CareSource Addiction Support Line

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

Dental Services

You should see a dentist every six months. Routine dental exams can help find and correct any problems before they get worse. One dental exam and cleaning is covered every 6 months for those 20 years old and under. For those age 21 and older, one dental exam and cleaning is covered each year. Please see the covered services chart on **page 13** to learn more.

Vision Services

Caring for your eyes can lead to a better quality of life. Your eyesight impacts your performance at work, school and home. Routine checkups and services from an eye doctor, as well as glasses, are covered by CareSource. Please see the covered services chart on **page 15** to learn more.

Superior Vision

Your vision benefits are covered by Superior Vision®. Find eye care at **FindADoctor.CareSource.com** or by calling Member Services. Make sure the provider knows you are covered by Superior Vision before you visit.

EXTRA BENEFITS

CareSource MyCare Ohio also offers extra services and/or benefits to their members.

Transportation

If you must travel 30 miles or more from your home to receive covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office. Please contact Member Services for assistance at least 48 hours (two business days) before you need a ride. You can get a ride in the same day for urgent trips like:

- when you are discharged from the hospital,
- need to go to an urgent care, or
- need to go to an urgent visit to your provider.

Let us know if you have any special needs or instructions when you schedule your ride. Examples are if you use a walker or wheelchair, need to meet at a back entrance, or do not have a phone where the driver can reach you. This will help us better meet your needs.

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

If you are determined eligible and enrolled in a home and community- based waiver program, there are also waiver transportation benefits available to meet your needs.

Transportation for Food

We offer rides to food pantries, grocery stores for curbside pickup, or other food distribution sites at no cost to you. These rides are in addition to the number you get for covered health services. You can get free rides to and from:

- Food pantries or food banks.
- Churches for food distribution pickups.
- Food distribution pickups through other community organizations.
- Grocery stores to pick up a grocery order (such as curbside pickup).

Call Member Services and tell them you are scheduling a food trip. Make sure that you call to schedule your ride two business days before your planned trip. Rides to grocery stores are for curbside pickup only. If you need a ride to get groceries for curbside pickup, make sure you give your order number, store location, and timeslot for pickup when you call.

myStrength

Take charge of your mental health! myStrength℠ has personalized support to better your mood, mind, body and spirit. Get it through your My CareSource account or visit bh.mystrength.com/CareSource to sign up.

MyHealth

Through MyHealth, adults ages 18 and older have access to interactive health assessments, small step guides and videos, and online tools to set and track health and wellness goals. You can even earn rewards for some activities. To get started, simply log in to your My CareSource account, click on the *Health* tab and scroll down to the *MyHealth* link.

MyResources

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

WHERE TO GET CARE

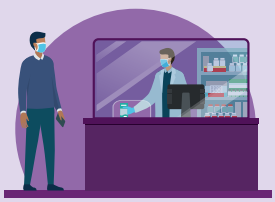
Access care from the right provider when you need it.

Primary Care Provider (PCP)

Used for common illnesses and advice. You will get most of your preventive care from your PCP. You should see your PCP the most often.

Telehealth

Visit with a provider by phone or computer from wherever you are. Ask your PCP if they offer telehealth. You can also talk to a doctor 24/7 through Teladoc®. Call 1-800-835-2362 or visit Teladoc.com/MyCareOhio to get started.



Convenience Care Clinics

Used for common illnesses like coughs, colds, sore throats and to get shots. They are found in many local drug and grocery stores.

Urgent Care

Used to treat non-life threatening issues like illnesses or a deep cut. Visit them when your PCP is not available and your health issue cannot wait.

Hospital Emergency Room (ER)

Used for life-threatening issues or emergencies like chest pain or a head injury. Call 911 or go to the nearest ER.

Not sure where to go for care? Call our CareSource24® Nurse Advice Line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. We are here for you 24 hours a day, 7 days a week, 365 days a year.

Primary Care Provider (PCP)

You can continue to get Medicare services from your doctors and other Medicare providers. A primary care provider (PCP) is a network provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, including your checkups and immunizations (shots), and he or she will treat you for most of your health care needs. Your PCP will be the first point of contact for all your health needs and will work with you to direct your health care. Your PCP should work with your CareSource MyCare Ohio Care Manager to coordinate your health and long-term care services. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital.

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

- Dizziness
- High/low blood pressure
- Swelling of the legs and feet
- High/low blood sugar
- Persistent cough
- Loss of appetite
- Restlessness
- Joint pains
- Colds/flu
- Headache
- Earache
- Backache
- Constipation
- Rash
- Sore throat
- Removal of stitches
- Vaginal discharge
- Pregnancy tests
- Pain management

It is important to contact your PCP before you see a specialist or after you have an urgent care or emergency department visit. This allows your PCP to manage your care for the best outcomes.

When You Can See a Non-Network Provider

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

Your PCP may decide you need medical care that you can only get from a doctor or other health care provider who is not in our network. If your PCP gets prior approval from CareSource MyCare Ohio for these services, they will be covered. For other times you may see an out-of-network provider please see **page 17**.

Changing Your PCP

If you want to change your PCP, please call Member Services to ask for the change to ensure your health and long-term care services are coordinated. You can change your PCP as often as once a month, if needed. If you need help finding a PCP or want the names of the PCPs in our network, you may visit **FindADoctor.CareSource.com**, or you can call Member Services.

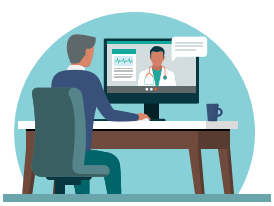
CareSource will send you a new member ID card to let you know that your PCP has been changed. If you no longer see the PCP that is on your ID card, CareSource MyCare Ohio will send you a new ID card. Member Services can also help you schedule your first appointment, if needed.

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

Appointments

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

CareSource can provide transportation to and from the provider's office. See **page 22** to learn more.



Telehealth

Telehealth is the direct delivery of health care to a patient via audio and/or video. Instead of coming into the office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost for CareSource MyCare Ohio members to use telehealth, and telehealth removes the stress of needing transportation services.

Medicaid members can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as prescribing medication(s). Check with your Medicare insurance plan for providers who offer telehealth services.

Teladoc

If your provider does not offer telehealth or has limited hours, you can speak to a medical provider 24/7 through Teladoc® from wherever you are. Use Teladoc for common health issues like a cold or flu, allergies and sinuses, pink eye, rashes, infections, and more! The provider can diagnose symptoms and send a prescription as needed.

Teladoc also has mental health providers available seven days a week from 7 a.m. to 9 p.m. They can help with anxiety, depression, stress, substance use, trauma, and more. Visits for mental health must be scheduled ahead of time.

Call 1-800-TELADOC (835-2362) or visit Teladoc.com/MyCareOhio to get started.

Convenience Care Clinics

If you can't see your PCP, we want to make it easy for you and your family to get care when you need it most.

A retail visit is quicker than a visit to urgent care or an ER. You can go to clinics inside of CVS® and Kroger® for basic care. At the clinic, you can:

- Get a flu shot.
- Get health screenings and physicals.
- Get care for aches and pains, sicknesses and minor injuries.

Most clinics are open in the evening, seven days a week. Visits can be scheduled for the same day. Often walk-ins are welcome. Find one near you at **FindADoctor.CareSource.com**.

Urgent Care

Go to urgent care if you cannot visit your provider quickly enough. They help keep an injury, sickness, or mental health issue from getting worse. You can find them at **FindADoctor.CareSource.com**. Always follow up with your PCP after your visit.

If you have a health need when you are traveling outside the counties that CareSource MyCare Ohio covers, see **page 29**.

Emergency Services

An illness, injury, symptom or condition that is so serious a reasonable person would get care right away to avoid major harm is called an emergency medical condition. Emergency services are covered when you have an emergency medical condition. Emergency services evaluate, treat or stabilize an emergency medical condition. They can include services given by a provider inside or outside a hospital, or medical transportation. You have the right to use any hospital or other appropriate setting for emergency services.

Emergency services are covered by Medicare. If you have an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your primary care provider (PCP) or the CareSource24 Nurse Advice Line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. Your PCP or CareSource24 can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to show them your CareSource MyCare Ohio member ID card and your Medicare ID card.
- If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call CareSource MyCare Ohio.
- If the hospital has you stay, please make sure that our plan is called within 24 hours.
- You should check in with your PCP or your Care Manager. They can check up on you and help with any follow up care you need.

Prior authorization is not required for emergency services. We will not refuse to cover emergency services and we do not limit the definition of what is an emergency.

Follow Up Care

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

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

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

When You Travel Outside of Our Service Area

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

- **If it's an emergency:** Call 911 or go to the nearest emergency room
- **If it's not an emergency:** Call your PCP or the CareSource24 Nurse Advice Line at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. They can help you decide what to do.
- **If you're not sure if it's an emergency:** Call your PCP or CareSource24 at **1-866-206-7861 (TTY: 1-833-711-4711 or 711)**. They can help you decide what to do.

PREVENTIVE CARE

Preventive care is key for the whole family. Seeing your PCP on a routine basis even if you are healthy helps your PCP find and treat problems early before they get worse. Check out the chart of recommended preventive care to get based on your age. The chart is only a guide. Work with your provider to get your preventive care. They will know which recommendations may be right for you based on your health history.

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

To access these and our clinical practice guidelines, please call Member Services or visit our website at **CareSource.com/MyCare.**

Healthchek (Well Child Exams)

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21. These exams are important to make sure that young adults are healthy and are developing physically and mentally. Members under the age of 21 years should have at least one exam per year.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental, and behavioral health exams, in addition to other care to treat physical, mental, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek services are available at no cost to members and include:

- Preventive check ups for young adults under the age of 21.
- Healthchek screenings:
  - Medical exams (physical and development screenings)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing
- Laboratory tests (age and sex appropriate exams)
- Immunizations
- Medically necessary follow up care to treat health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - visits with a primary care provider, specialist, dentist, optometrist and other CareSource MyCare Ohio providers to diagnose and treat problems or issues
  - inpatient or outpatient hospital care
  - clinic visits
  - prescription drugs
  - Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Remember: *Some services may require a referral from your PCP or prior authorization by CareSource MyCare Ohio*. Also, for some EPSDT items or services, your provider may request prior authorization for CareSource MyCare Ohio to cover things that have limits or are not covered for members over age 20. Please see **page 11** to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 who have special health care needs. Please see **page 5** to learn more about the care management services offered by CareSource MyCare Ohio.

How to Get Healthchek Services

Call your PCP or dentist to schedule an appointment for a Healthchek exam. Make sure to ask for a Healthchek exam when you call. If you have questions or would like to learn more about the Healthchek program, please call Member Services. We can help you:

- Access care
- Find a provider
- Make an appointment
- Find out what services are covered and which ones may need prior authorization
- Arrange a ride if you need one
- Get referrals for Women, Infant and Children (WIC), Help Me Grow, Bureau for Children with Medical Handicaps (BCMH), Headstart and community services such as food, heating assistance, and more.

PHARMACY

Prescription Drugs – Not Covered by Medicare Part D

While most of your prescription drugs will be covered by Medicare Part D, there are a few drugs that are not covered by Medicare Part D but are covered by CareSource MyCare Ohio. You can view our plan's ***List of Covered Drugs*** on our website at **CareSource.com/oh/plans/mycare/plan-documents**. Drugs with an "ADD" are not covered by Medicare Part D but are covered by CareSource MyCare Ohio. You do not have any copays for drugs covered by our plan.

We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior authorize a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first.
- Some drugs may have quantity (amount) limits.

If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing. You can call Member Services to request information on medications that require prior authorization. You can also look on our website at **CareSource.com/oh/plans/mycare/plan-documents**. Make sure you are only looking at the drugs with "ADD" to see if they require prior authorization. Please note that our list of medications that require prior authorization can change so it is important for you and/or your provider to check this information when you need to fill or refill a medication.

As a reminder, because you have chosen or were assigned to receive only your Medicaid-covered services from our plan, CareSource MyCare Ohio does not provide coverage for your Medicare Part D prescription drugs. CareSource MyCare Ohio will only cover certain drugs that are not covered by Medicare Part D.

Ask Your CareSource Pharmacist

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

Medication Therapy Management

Using medications the right way is vital to your health. Our Medication Therapy Management (MTM) program will:

- Help you safely use your medications.
- Help your doctors and other caregivers work better together.
- Help you learn about your drugs and the right way to use them.
- Help your overall health.

You can work one-on-one with a pharmacist through the MTM program. They can go over and help you manage your medications. Ask your pharmacist if they are part of the MTM program. You can also call Member Services to learn more.

Medication Disposal

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

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

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

MEMBER RIGHTS

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

- To receive all information and services that our plan must provide. This includes information about CareSource, our services, our providers, and member rights and responsibilities. It can also be information about any provider incentive plan we may have.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be able to discuss medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To be able to participate with practitioners in making decisions relating to your health care.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To be able to take part in decisions about your health care. Instances believed to work against your best interest may be overridden.
- To get information on any medical care treatment, given in a way that you understand and can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in Federal regulations.
- To request, and receive a copy of your medical records, and to be able to ask that a record be changed or corrected if needed.
- To be able to say yes or no to having any information about you given out unless we have to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or our plan must talk to you about what could happen and must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See “How to Let CareSource MyCare Ohio Know if You Are Unhappy or Do Not Agree With a Decision We Made – Appeals and Grievances,” **page 45** of this handbook for information.

- To be able to get all MCOP-written member information from our plan:
  - at no cost to you;
  - in the prevalent non-English languages of members in the MCOP's service area;
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help, free of charge, from our plan and its providers if you do not speak English or need help in understanding information.
- To be able to get help, free of charge, with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (that is a living will). See **page 58**, which explains about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To be free to carry out your rights and know that the MCOP, the MCOP's providers or the Ohio Department of Medicaid will not hold this against you.
- To know that we must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- To change your primary care provider (that is your doctor) no more than once a month.
- If you are a female, to be able to go to a woman's health provider in our network for Medicaid covered woman's health services.
- To be able to get a second opinion for Medicaid covered services from a qualified provider in our network. If a qualified provider is not able to see you, we must set up a visit with a provider not in our network at no cost to you.
- To get information about CareSource MyCare Ohio from us.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

  The Ohio Department of Medicaid
  Office of Human Resources, Employee Relations
  P.O. Box 182709
  Columbus, Ohio 43218-2709

  E-mail: ODM_EmployeeRelations@medicaid.ohio.gov
  Fax: (614) 644-1434

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

Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see our Privacy Practices on **page 38**.

MEMBER RESPONSIBILITIES

As a member of CareSource MyCare Ohio you must also be sure to:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the plans and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your member ID card and present it when receiving services.
- Never let anyone else use your ID card.
- Notify your county caseworker and CareSource MyCare Ohio of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of CareSource MyCare Ohio's covered counties or service area.
- Let CareSource MyCare Ohio and your county caseworker know if any member of your family has other health insurance coverage.
- Provide the information that CareSource MyCare Ohio and your health care providers need in order to provide care for you.
- Understand as much as possible about your health issues and take part in reaching goals that you and your health care provider agree upon.
- Let us know if you suspect health care fraud or abuse.

Visit **CareSource.com/MyCare** for any updates to member rights and responsibilities.

PRIVACY PRACTICES

This notice describes how health information about you may be used and given out. It also tells how you can get this information. Please review it carefully. We will refer to ourselves simply as “CareSource” in this notice.

Your Rights

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

Get a copy of your health and claims records.

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

Ask us to fix health and claims records.

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

Ask for private communications.

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

Ask us to limit what we use or share.

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

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

You can ask for a list (accounting) of the times we've shared your health information. This is limited to six years before the date you ask. You may ask who we shared it with, and why. We will include all the disclosures except for those about:

- care,
- payment(s),
- health care operations, and
- certain other disclosures (such as any you asked us to make).

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

Get a copy of this privacy notice.

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

Give CareSource consent to speak to someone on your behalf.

You can give CareSource consent to talk about your health information with someone else on your behalf.

If you have a legal guardian, that person can use your rights and make choices about your health information. CareSource will give out health information to your legal guardian. We will make sure a legal guardian has this right and can act for you. We will do this before we take any action.

File a complaint if you feel your rights are violated.

You can complain if you feel we have violated your rights by contacting us. Use the information at the end of this notice.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, call 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not take action against you for filing a complaint. We may not require you to give up your right to file a complaint as a condition of:

- care,
- payment,
- enrollment in a health plan, or
- eligibility for benefits.

Your Choices

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

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

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

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

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

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

Consent to Share Health Information

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

Other Uses and Disclosures

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

Help you get health care treatment. We can use your health information and share it with experts who are treating you.

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

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

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

Pay for your health care. We can use and give out your health information as we pay for your health care.

Example: We share information about you with your dental plan to arrange payment for your dental work.

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

To help with public health and safety issues. We can share health information about you for certain reasons such as:

- Preventing disease
- Helping with product recalls
- Reporting harmful reactions to drugs
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

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

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

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

To work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when a person dies.

To address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

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

To respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a court order.

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

Our Responsibilities

- We protect our members' health information in many ways. This includes information that is written, spoken or available online using a computer.
  - CareSource employees are trained on how to protect member information.
  - Member information is spoken in a way so that it is not inappropriately overheard.
  - CareSource makes sure that computers used by employees are safe by using firewalls and passwords.
  - CareSource limits who can access member health information. We make sure that only those employees with a business reason to access information use and share that information.
- We are required by law to keep the privacy and security of your protected health information. We are required to give you a copy of this notice.
- We will let you know quickly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice. We must give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Effective date and changes to the terms of this notice

The original notice was effective April 14, 2003, and this version was effective June 18, 2018. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice. The new one would apply to all health information we keep. If this happens, the new notice will be available upon request. It will also be posted on our web site. You can ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

The CareSource Privacy Officer can be reached by:

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

Email: HIPAAPrivacyTeam@caresource.com

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

FRAUD, WASTE AND ABUSE

Our Program Integrity team handles cases of fraud, waste and abuse. Examples are:

Providers who:

- Order drugs, equipment or services that are not medically necessary.
- Do not give medically necessary services due to lower reimbursement rates.
- Bill for tests or care that they do not give.
- Use wrong medical coding on purpose to get more money.
- Have you come for more visits than are needed.
- Bill for more expensive care than what you get.
- Unbundle services to get a higher repayment.

Words to Know

Fraud – the purposeful misuse of or for gain of benefits.

Waste – using more benefits than what is needed.

Abuse – an action that causes unneeded costs to CareSource.

Pharmacies that:

- Do not fill prescriptions as written by your provider.
- Send claims for a brand-name drug that costs more but give you a generic or a cheaper drug.
- Give less than the prescribed amount and do not let you know to get the rest of your medication.

Members who:

- Sell prescribed drugs or try to get controlled drugs from more than one doctor or pharmacy.
- Change or forge prescriptions.
- Use pain medications you do not need.
- Share your ID card with someone else.

- Do not tell us that you have other health insurance.
- Get equipment and supplies you do not need.
- Get care or drugs using some other person's ID.
- Give wrong symptoms to get treatment, drugs and other care.
- Have too many ER visits for problems that are not an emergency.
- Lie about your eligibility for Medicaid.

If you are proven to have misused your benefits, you might:

- Have to pay back money that was paid for care that was misused.
- Be charged with a crime and go to jail.
- Lose your Medicaid benefits.

Please report fraud, waste, or abuse:

1. Call **1-844-415-1272** (TTY: 711).
2. Fill out the Fraud, Waste and Abuse Reporting Form. It is at **CareSource.com**. Choose *Forms* under *Member*.
3. Write a letter to:
   CareSource
   Attn: Program Integrity
   P.O. Box 1940
   Dayton, OH 45401-1940
4. Email **fraud@CareSource.com**.
5. Fax the form or other information to 1-800-418-0248.

You do not have to give us your name when you write or call. If you are not worried about giving your name, you may also send an email or fax. Please give us as many facts as you can. Add names and phone numbers. If we do not get your name, we will not be able to call you back for more information. What you share will be kept private as allowed by law.

Others may read your email without you knowing or saying it is okay if your email is not secure. Please do not use email to send a member ID number, social security number or any health information. Please use the form or phone number above. This can help protect your privacy.

You can also report directly to the state of Ohio by using one of the methods below:

- ✓ Ohio Department of Medicaid (ODM)
  Phone: 1-614-466-0722
  Online: https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud?adlt=strict
- ✓ Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU)
  Phone: 1-800-642-2873
  Online: https://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud
- ✓ The Ohio Auditor of State (AOS)
  Phone: 1-866-FRAUD-OH
  Email: fraudohio@ohioauditor.gov

HOW TO LET CARESOURCE MYCARE OHIO KNOW IF YOU ARE UNHAPPY OR DO NOT AGREE WITH THE DECISION WE MADE – APPEALS AND GRIEVANCES

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

To contact us, you can:

- Call the Member Services Department at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**, or
- Fill out the form in your Member Handbook on **page 58**, or
- Call the Member Services Department to request they mail you a form, or
- Visit our website at **CareSource.com/MyCare**, or
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your CareSource MyCare Ohio member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Words to Know

Appeal – Asking us to review a decision that denied a benefit or service.

Grievance – A formal complaint about us, our providers, or the care you get.

Mail the form or your letter to:
CareSource
Attn: Member Grievances & Appeals
P.O. Box 1947
Dayton, OH 45401-1947

CareSource MyCare Ohio will send you something in writing if we make a decision to:

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

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

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

If you do not agree with the decision or action listed in the letter, and you contact us within **60 calendar days** of getting our letter to ask that we change our decision or action, this is called an **appeal**. The 60 calendar day period begins on the day after the mailing date on the letter. If we have made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action as a result of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through CareSource MyCare Ohio's appeal process.**

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

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

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

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

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-605-3040 or 1-800-324-8680
TTY: 1-800-292-3572

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
1-800-686-1526

STATE HEARINGS

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

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

If you want a state hearing, you or your authorized representative must request a hearing **within 90 calendar days**. The 90-calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before you get all the approved services, your letter will tell you how you can keep getting the services if you choose to and when you may have to pay for the services.

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

To request a hearing:

- You can sign and return the state hearing form to the address or fax number listed on the on the form,
- Call the Bureau of State Hearings at 1-866-635-3748,
- Submit your request online at https://hearings.jfs.Ohio.gov/apps/share/#_frmlogin
- Submit your request via e-mail at bsh@jfs.Ohio.gov

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-8889.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the MCOP or Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than 3 working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

UTILIZATION MANAGEMENT

Our Utilization Management (UM) team includes non-clinical staff, registered nurses, physicians, mental health specialists, and other health experts. They review the health care you get based on a set of guidelines. They go over this care to make sure it is the best for your needs. You can ask how care is reviewed. You can ask about:

- Preservice review
- Urgent concurrent review
- Post service review
- Filing an appeal

We do not reward providers or our staff for denying services. We want you to get the care you need. We can get you an interpreter if you or your family's primary language is not English. We can also help if you have problems with your eyesight, hearing, or have trouble reading.

Call Member Services and ask for the UM team if you have questions. Please keep in mind:

- We are open for calls Monday through Friday from 8 a.m. to 5 p.m.
- You can leave a message about UM issues after these hours.
- Reach UM using the *Tell Us form* at **CareSource.com**.
- UM staff who call you will say their name and title and that they are from CareSource.

Authorization Time Frames

We will decide standard requests within 10 calendar days after we get your request. We will tell you and your provider if it has been approved. You, your provider, or CareSource can ask for more time to review. The review can last up to an additional two weeks.

Your provider or CareSource can ask for an urgent authorization. This would be for a non-life-threatening issue that a provider who knows your issue thinks needs quick medical care. This helps prevent:

- ✓ A serious threat to life, limb, or eyesight.
- ✓ Worsening function or damage to any part of the body that threatens the body's ability to get better.
- ✓ Severe pain that cannot be managed without quick medical care.

New Care Approvals

We may decide to cover a new treatment that is not covered by Medicaid. This can be new:

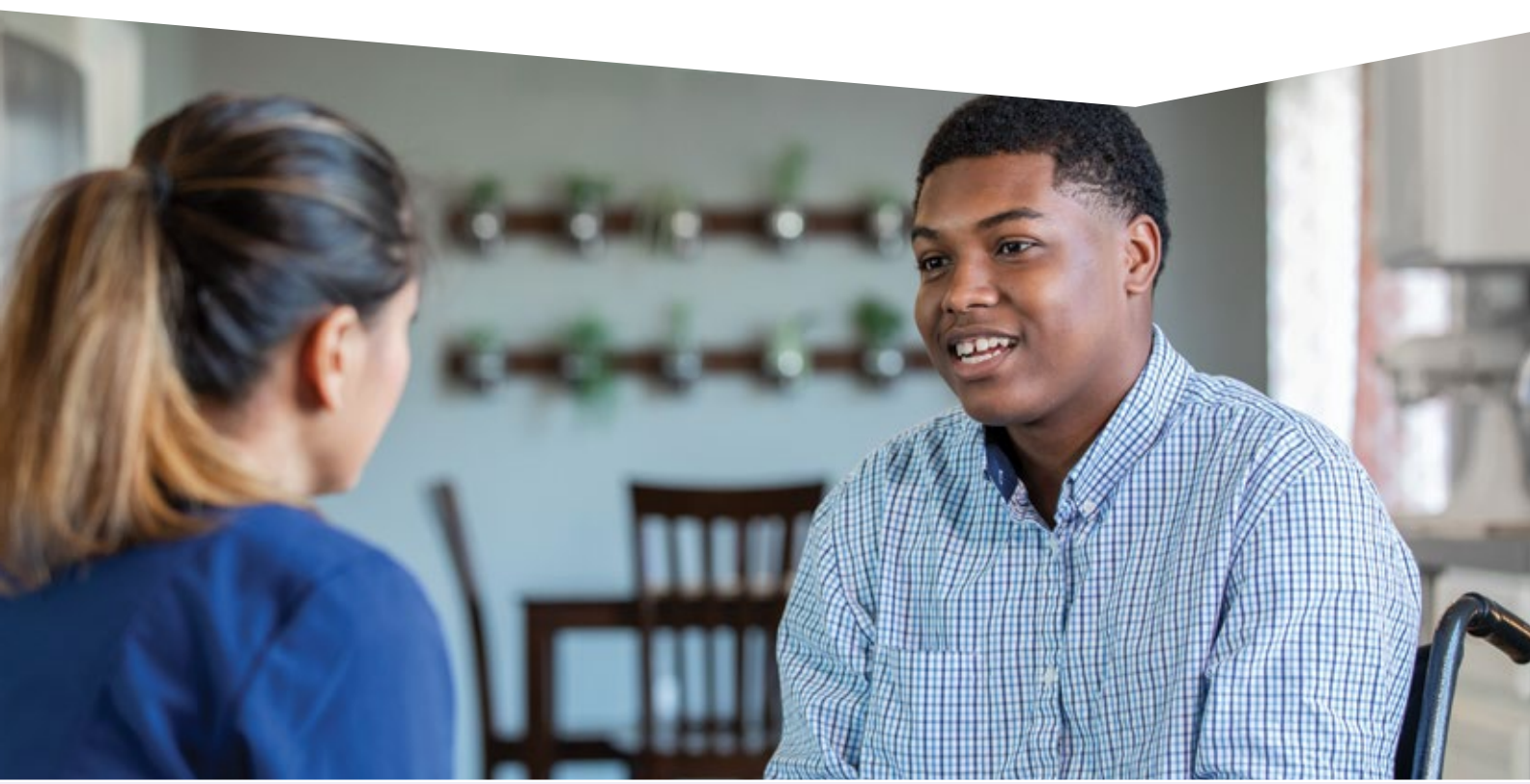
- Health care services
- Medical devices
- Therapies
- Treatments

Review of New Technology

We depend on research and advances in science to provide you with evidence-based, high quality-care. Our New Technology Committee, made up of physicians across CareSource, evaluate medical advances to determine their quality and safety. Network providers may submit requests for evaluation. By regularly reviewing medical technologies and our benefit coverage, we strive to provide up-to-date, effective, and affordable medical care.

We review requests for new technology that are not currently covered. This involves:

- Changes to Medicaid rules
- External technology assessment rules
- Food and Drug Administration (FDA) approvals
- Medical literature recommendations



MEDICAID ELIGIBILITY AND OTHER INSURANCE INFORMATION

Accidental Injury or Illness (Subrogation)

If you must see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services Department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay the doctor's and/or hospital's bill. When you call we will need the name of the person at fault, their insurance company and the name(s) of any attorney(s) involved.

Other Health Insurance (Coordination of Benefits – COB)

We are aware that you also have health coverage through Medicare. If you have any other health insurance with another company, it is very important that you call the Member Services Department and your county caseworker about the insurance. It is also important to call Member Services and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with payment of potential medical bills.

You will need to show your CareSource MyCare Ohio member ID card, your Medicare ID card and any other health insurance ID cards at all of your appointments. Please bring all your health insurance ID cards with you to every appointment.

Members with other insurance: CareSource MyCare Ohio follows Ohio insurance guidelines for members who have other insurance. Your other insurance coverage is considered your primary coverage. You should follow the guidelines of your primary insurance when you get medical care. Be sure to show your providers and pharmacists your Medicare ID card, your CareSource MyCare Ohio member ID card and any other insurance coverage you have at every visit.

Providers will bill your primary insurance first. After your primary insurance pays its allowable amount, your provider will bill CareSource MyCare Ohio. CareSource MyCare Ohio will pay the remaining amount after the primary insurance payment (up to the amount CareSource MyCare Ohio would have paid as the primary insurance).

You should let CareSource MyCare Ohio and your county caseworker know right away if your other insurance changes.

Loss of Insurance Notice (Certificate of Creditable Coverage)

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company that says you no longer have insurance. It is important that you keep a copy of this notice for your records because you might be asked to provide a copy.

Loss of Medicaid Eligibility

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, our plan would be told to stop your membership as a Medicaid member, and you would no longer be covered.

Automatic Renewal of MCOP Membership

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

MEMBERSHIP TERMINATIONS

We hope you are happy with CareSource. Please let us know if you have any issues or concerns so we can try to resolve them.

Ending Your MCOP Membership

You live in a MyCare Ohio mandatory enrollment area, which means you must select a MyCare Ohio managed care plan unless you meet one of the exceptions listed on **page 53**. If your area would change to a voluntary enrollment area, the Ohio Department of Medicaid would notify you of the change.

Because you chose or were assigned to only have your Medicaid benefits through CareSource MyCare Ohio, you can only end your membership at certain times during the year. You can choose to end your membership during the first three (3) months of your initial membership or during the annual open enrollment month. The Ohio Department of Medicaid will send you something in the mail to let you know when it is your annual open enrollment period. If you live in a MyCare Ohio mandatory enrollment area, you must choose another MyCare Ohio plan to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment month you can call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay Services at 7-1-1. You can also submit a request online to the Medicaid Hotline website at **www.ohiomh.com**. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

Choosing A New Plan

If you are thinking about ending your membership to change to another health plan, you should learn about your choices, especially if you want to keep your current provider(s) for Medicaid services. Remember, each health plan has a network of providers you must use. Each health plan also has written information which explains the benefits it offers and the rules you must follow. If you would like written information about a health plan you are thinking of joining, or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1. You can also find information about the health plans in your area by visiting the Medicaid Hotline website at **www.ohiomh.com**.

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

You can request to receive both your Medicare and Medicaid benefits from CareSource MyCare Ohio and allow us to serve as your **single point of contact** for all your Medicare and Medicaid services. If you would like more information or to request this change, you can contact the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1.

Just Cause Membership Terminations

Sometimes there may be a special reason that you need to end your health plan membership. This is called a "just cause" membership termination. Before you can ask for a just cause membership termination you must first call your MyCare Ohio managed care plan and give them a chance to resolve the issue. Requesting a just cause membership termination will not return you to the Medicaid Fee-For-Service (FFS) program, but it may allow you to change your health plan outside of the open enrollment period. If your MyCare Ohio plan cannot resolve the issue, you can ask for a just cause termination at any time if you have one of the following reasons:

1. You move and your current MCOP is not available where you now live, and you must receive non-emergency medical care in your new area before your MCOP membership ends.
2. The MCOP does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and all the services aren't available on your MCOP's panel.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCOP's panel.
5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your MCOP's panel and he/she was the only PCP on your MCOP's panel that spoke your language and was located within a reasonable distance from you. Another health plan has a PCP on their panel that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. Other – If you think staying as a member in your current health plan is harmful to you and not in your best interest.

You may ask to end your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1. The Ohio Department of Medicaid will review your request to end your membership for just cause and decide if you meet a just cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your just cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Things to Keep in Mind if You End Your Membership

If you have followed any of the above steps to end your membership, remember:

- Continue to use CareSource MyCare Ohio doctors and other providers until the day you are a member of your new health plan, unless you are still in your transition period.
- If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan's Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680. TTY users should call Ohio Relay at 7-1-1.
- If you were allowed to return to the previous Medicaid card and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new health plan and have any Medicaid services scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: *when you are getting home health, private duty nursing, mental health, substance use disorder, dental, vision and waiver services.*

Can CareSource MyCare Ohio End My Membership?

CareSource MyCare Ohio may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended. The reasons that we can ask to end your membership are:

- For fraud or for misuse of your member ID card
- For disruptive or uncooperative behavior to the extent that it affects the MCOP's ability to provide services to you or other members.

CareSource MyCare Ohio provides services to our members because of a contract that our plan has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid, you can call or write to:

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

1-800-324-8680 (Monday through Friday, 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m.)
TTY users should call Ohio Relay at 7-1-1

You can also visit the Ohio Department of Medicaid on the web at: http://www.Medicaid.Ohio.gov/providers/managedcare/integratingMedicareandMedicaidbenefits.aspx.

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address or income or other insurance.

You can contact CareSource MyCare Ohio to get any other information you want including the structure and operation of our plan and how we pay our providers or if you have any suggestions on things we should change. Please call the Member Services department at **1-855-475-3163 (TTY: 1-833-711-4711 or 711)**.

ADVANCE DIRECTIVES

Many people today worry about the medical care they would get if they became too sick to make their wishes known. An advance directive is a written record about your future care and treatment. This includes mental health care. It helps your family and providers know your wishes about your care. Some people may not want to spend months or years on life support. Others may want all steps taken to live longer.

You have a choice.

You do not have to make an advance directive, but we suggest you do. It will ensure your wishes are followed when you are not able to be consulted. It is best to make them while you are healthy. Providers must make it clear that you have a right to state your wishes about your health care. They must ask if your wishes are in writing. They also must add your advance directive to your medical record.

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

- It is a choice to write one.
- The law states that you can make choices about health care and surgical treatment, such as agreeing to or refusing care.
- Having one does not mean you want your life to end.
- You can choose a person to make health care choices for you when you cannot make them. You may also use it to keep certain people from making decisions for you.
- You must be of sound mind to make one.
- You must be at least 18 years old or an emancipated minor to have one.
- Having one will not change other insurance.
- They can be changed or ended at any time.

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

What kinds of forms are there?
Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, a Health Care Power of Attorney or a Do Not Resuscitate (DNR) Order. You fill out an advance directive while you're able to act for yourself. The advance directive lets your provider 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.

Do I need a lawyer?
No, you don't need a lawyer to fill out an advance directive. You may want to speak with a lawyer for help.

Do the people giving medical care have to follow my wishes?
Yes, if your wishes follow state law. Ohio law has a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against their conscience. If so, they will help you find someone else who will follow your wishes. If you have any concerns about someone not following your wishes, you may file a complaint with the Ohio Department of Health.

Can I change my advance directive?
Yes, you can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio's law. You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. 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?
If you are in terminal condition or a permanently unconscious state, then Ohio law recognizes an order of decision makers if you are unable to make health care decisions for yourself and you do not have an advance directive. Ohio law recognizes this order of your decision makers: legal guardian, spouse, majority of adult children, parents, and other nearest relative.

Where do I get advance directive forms?
Many of the people and places that give you medical care have advance directive forms. A lawyer could also help you.

What do I do with my forms after filling them out?
You should give copies to your provider 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 Care Manager, family or friends about what you have done. Don't 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 ID Card, or
2. You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

What is a guardian?

A guardian is someone chosen by a court to be legally in charge for another person.

When will a guardian be chosen?

A court will choose a guardian for someone who can no longer make safe choices by themselves. This is usually due to legal or mental incapacity. In certain situations a minor may also have a guardian chosen for them.

How do I get a guardianship?

Only a court can choose a guardian. The court that chooses a guardian is your local court. This could differ based on where you live. Call your local court, a local lawyer, or local legal aid service for more information.

MEMBER STANDARDIZED APPEAL FORM

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

- Attach copies of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

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

WORD MEANINGS

Abuse: An action that causes unneeded costs.

Advance Directives: A written record about your future care and treatment.

Additional Demonstration Drug: Over-the-counter (OTC) items and non-Part D drugs you can get as part of your plan. You can get OTC items at your local network pharmacy.

Appeal: Asking us to review a decision that denied a benefit or service.

Appointment: A visit you set up to see a provider.

Authorized Representative: A person you allow to make health decisions for you. We must have this on record in writing.

Behavioral Health Services: Preventing, diagnosing and treating mental health and substance use disorder issues.

Benefits: Your covered health care services. Benefits are also the extra programs and services that you get through CareSource.

Business Days: Monday through Friday, 7 a.m. to 8 p.m. except for holidays.

Calendar Days: Each day of the week, along with weekends and holidays.

Care Management: A team of registered nurses, social workers, and other outreach workers who work with you, your PCP and/or other specialists, and any family or other caregivers you would like to help coordinate your care.

Chronic Condition: A problem that affects your health for a long period of time.

Claim: An ask for a benefit made by you or your provider for services you think are covered. This includes a reimbursement if you have already paid for the service.

Co-payment: Part of the cost for care you must pay.

Convenience Care Clinic: A health clinic in a retail or grocery store. These are often open late and open on weekends to care for routine sicknesses.

Covered Services: Medically necessary care that we pay for.

Diagnostic: Tests to figure out what your health problem is.

Disenrollment: The removal of a member from CareSource.

Durable Medical Equipment (DME): Supplies that can be used more than once for health services.

Emergency Medical Condition: An illness, injury, symptom, or condition that needs immediate care.

Emergency Medical Transportation: Ground or air ambulance services for an emergency medical condition.

Emergency Room Care: Services you get in an emergency room.

Emergency Services: Services that are needed to check, treat or stabilize an emergency medical condition.

EPSDT: Early and Periodic Screening, Diagnostic and Treatment. This is preventive care given to those under the age of 21.

Excluded Services: Health services that CareSource does not pay for or cover.

Explanation of Benefits (EOB): A statement you may get that shows what health care services were billed to CareSource and how they were paid. An EOB is not a bill.

Fraud: Misusing benefits on purpose.

Grievance: A complaint about us or our providers.

Guardian: A person appointed by a court to be legally responsible for another person.

Health Care Services: Preventive or diagnostic treatments that are linked to your health.

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

Home Health Care: The medical and health services that are given in your home by a provider.

Hospice Services: Services that give comfort and support for a person in the last stages of a terminal illness.

Hospitalization: Care in a hospital where you are admitted as an inpatient.

Hospital Outpatient Care: Care in a hospital. It often includes an overnight stay.

Medicaid: Federal health insurance for low-income families, children, pregnant women, people with disabilities and others.

Medically Necessary: Care needed to diagnose or treat an illness, injury, condition, disease or its symptoms.

Member: A person who is enrolled with CareSource and gets health care from our providers.

Network: CareSource's contracted providers available to CareSource's members.

Network Provider or In-Network Provider: A doctor, hospital, pharmacy or other provider that gives care to CareSource members. The Find a Doctor online tool has the most up-to-date list of network providers near you.

Outpatient Care: A procedure that can be done without an overnight stay in the hospital.

Out-of-Network Provider: A doctor, hospital, pharmacy or other provider that has not signed a contract to give care to CareSource members. We will not pay for services from these providers unless it is an emergency, we have given prior authorization or you are getting family planning services.

Over-the-Counter (OTC) Drug: A drug you can often buy without a prescription.

Pharmacy: Where to go to get medications or prescriptions.

Physician Services: Health care that a doctor gives or arranges.

Post-stabilization Care Services: Follow up care you receive once you are stable after an emergency.

Preauthorization: Approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you.

Primary Care Provider (PCP): A network provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

Prescription: A health provider's order for a drugstore to fill and give a drug to their patient.

Preventive Care: Routine care like screenings and exams. You get this care to help stop a health problem from occurring.

Prior Authorization: Approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you.

Provider Directory: A list of providers in the CareSource MyCare Ohio network.

Referral: A written order from your provider for you to see a specialist or get certain health care.

Rehabilitation Services and Devices: Help you keep, get back, or improve skills and functioning for daily life. The skills may have been lost or harmed because you were sick, hurt or disabled.

Service Area: Where CareSource MyCare Ohio is an option for coverage for Medicaid consumers.

Skilled Nursing Care: Care from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a certain kind of medicine or has special training in a certain type of health care. Substance use: Harmful use of substances, like alcohol and illegal drugs.

Telehealth: A visit with a provider using a phone or computer.

Urgent Care: Place to get care for an injury or sickness that needs to be treated right away. It is for mostly not life-threatening issues.

Utilization Management: A review of care you get to make sure it works and is needed.

Waiver Program: The Medicaid waiver program allows states to choose groups of people with particular needs and health conditions to receive tailor-made health care options at home or within the community.

Waste: Using more benefits than what is needed.

CareSource®

MyCareOhio
Connecting Medicare + Medicaid

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