Healthy Indiana Plan (HIP)
Hoosier Healthwise (HHW)

2025 Member Handbook

CareSource®

CONTACT US

Member Services

Phone: **1-844-607-2829** (TTY: 1-800-743-3333 or 711)
Monday through Friday, 8 a.m. to 8 p.m. Eastern Time

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

Online: **CareSource.com**
MyCareSource.com
This is a private online account where you can chat with Member Services.

CareSource24® Nurse Advice Line

1-844-206-5947 (TTY: 1-800-743-3333 or 711) 24/7, 365 days a year (including observed holidays)

CareSource Transportation Services

1-844-607-2829 (TTY: 1-800-743-3333 or 711)

Hours of Operation

CareSource is open for business Monday – Friday, 8 a.m. to 8 p.m. Eastern Time

CareSource is closed on these days in 2025:

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

Accommodations

Is there a CareSource member in your family who:

- Does not speak English?
- Has difficulty hearing or seeing?
- Has trouble reading or speaking English?

We can help. We have Spanish and Burmese speaking staff. We can also get you sign language or other language interpreters. We can go through this information in English or in your primary language. Interpreters can help you talk with us or your health care provider. They can help you with a grievance or an appeal. A grievance or an appeal is when you are not happy with a decision, like a denial of coverage. Interpreters can help over the phone or in person at a health care visit. You can get this handbook for free in other formats. These formats include large print, braille or audio. You can also get other important documents in other formats for free, such as:

- Explanation of Benefits (EOB)
- Provider Directory

This is a free service. These formats include large print, braille or audio.

Call Member Services five business days before your health care provider visit for a sign language interpreter. Call us four business days before your visit for other language interpreters. You can get these services at no cost to you.

Call us toll free at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to ask for an interpreter, to speak to Spanish or Burmese speaking staff or to ask for material in other formats. We are open Monday through Friday, 8 a.m. to 8 p.m. Eastern Time. You can also dial 9 to be quickly connected to an interpreter.

YOU ARE NOT ALONE.

Are you or someone you know in crisis?

If you are thinking of hurting yourself or someone else, please ask for help. All calls are confidential.

988 Suicide and Crisis Lifeline – 9-8-8

STRUGGLING WITH SUBSTANCE USE DISORDER?

There is help if you or a loved one has drug or alcohol addiction. Start your road to recovery today.

CareSource Addiction Services Hotline: **1-833-OPIOIDS (674-6437)**

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Welcome to CareSource

We are excited to serve you and other Hoosier Healthwise (HHW) and Healthy Indiana Plan (HIP) members in Indiana.

At CareSource, our mission is to make a lasting difference in our members' lives by improving their health and well-being. We know life is busy. We are here to make your health journey easier. We believe you deserve more than high quality health care. You deserve *Health Care with Heart®*.

If you have questions, please call Member Services at **1-844-607-2829** (TTY 1-800-743-3333 or 711).

QUICK START GUIDE

Follow the steps below to make the most of your health plan.

1) Review Your CareSource ID Card(s)

All members will get a CareSource member ID card with your New Member Booklet. This is the booklet you get when you first become a member. Each card is good while you are a member of that CareSource plan. Cards do not expire. Contact Member Services if you:

- Did not receive an ID card(s)
- Lost your ID card(s)
- Need a new ID card(s)

You can also sign into your My CareSource® account to order an ID card or use the mobile app to view your digital member ID card. You can learn more about My CareSource and the CareSource mobile app below.

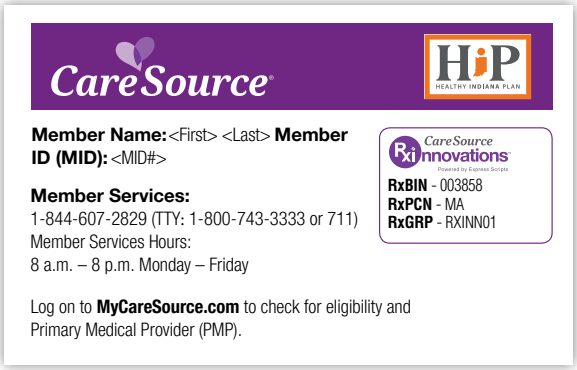
Always keep your ID card with you.

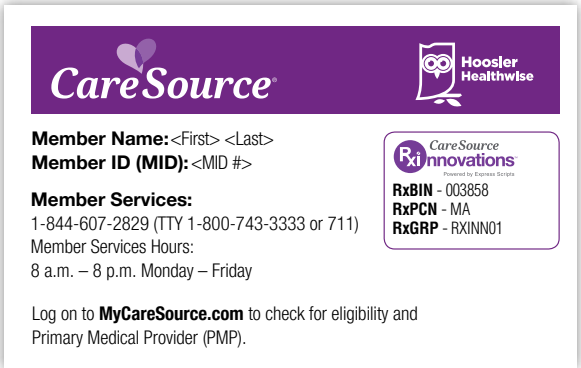
You will need your ID card when you get health care, prescription drugs or special services. You can also view it on the mobile app. You will need your ID card when you:

- See your primary medical provider (PMP) or primary dental provider (PDP)
- See a specialist (expert) or other health care provider
- Have health tests or other prescribed procedures
- Use a convenience care clinic (usually located in drug or grocery stores)
- Go to the pharmacy to fill your prescriptions

If you do not have your ID card with you at the time of your appointment, you can still be seen by the doctor. You need to have your Medicaid eligibility verified. You will have to provide one of the following to verify eligibility to receive services:

- Member ID number
- Social Security Number and date of birth
- First and last name





2) Make Sure Your Providers Are in Network

CareSource does not pay for charges from out-of-network providers in most cases. If you are seeking family planning services, have an emergency, or have gotten prior approval, you may go to an out-of-network provider.

Use the Find a Doctor online tool to search for a health care provider at **findadoctor.CareSource.com** or on the mobile app. You can also call Member Services. The phone number is **1-844-607-2829** (TTY: 1-800-743-3333 or 711). It is listed at the bottom of each page of this handbook.

Call Member Services:

- Before your health visits if you are a new member
- If you have ongoing health care services planned

Your services may not be covered if your provider is outside of our network. Member Services can help if your provider is not in our network. They can coordinate your existing care or help you find a new health care provider in network.

Call Member Services to check if your care needs to be approved. Some of this care includes:

- Transplants (like kidney or bone marrow)
- Any surgery or medical procedure
- Cancer care
- Care after a hospital stay within the last 30 days
- Non-routine dental or eye care (like braces or eye surgery)
- Equipment (like a breathing machine for asthma)
- Home health care

Emergency care does NOT need prior approval.

3) Make Sure Your Prescriptions Are on the CareSource Preferred Drug List

CareSource uses the Indiana Medicaid Statewide Uniform Preferred Drug List (SUPDL). Use the **Find My Prescriptions** search tool on our website to see covered drugs and medical supplies. See page 47 to learn more.

1. Click *Search Prescriptions*
2. Enter the names of your drugs into the search tool.

This will tell you more about how medicine and medical supplies are managed, like if your drug needs prior approval.

4) Set Up Your My CareSource Account

You can see your account information by registering at **MyCareSource.com**. This is safe and private. You can use your My CareSource account to:

- Choose the way you would like for us to communicate with you
- Change your health care provider
- Ask for a new ID card
- View claims and plan details
- Update your contact information
- Learn about our rewards program

It's easy to do.

1. Go to **MyCareSource.com**.
2. Click the *Sign Up* button at the bottom of the page.
3. Follow the instructions.

5) Get the CareSource Mobile App

Our mobile app lets you manage your health plan on-the-go. You can do things like view your ID card, find a doctor, access your My CareSource account and more! You can manage yourself and your family members who are CareSource members on one account. The app is free. Get the CareSource mobile app through the App Store® for iPhone® or Google Play® for Android®.

6) Fill out your Health Needs Screening (HNS). New Members Get a $30 Walmart® Gift Card

We want to help you stay healthy. The HNS has a list of questions to answer and can help us better understand your needs. Answering the questions will let CareSource help you with:

- Physical health
- Substance use disorders
- Social needs

You can complete your HNS in one of these ways:

1. **Phone:** Quickest and easiest way! Call **1-833-230-2011** to complete the health survey over the phone. CareSource staff will help you Monday - Friday between 7 a.m. to 6 p.m. Eastern Time.
2. **Online:** Log in to **MyCareSource.com** or scan this QR code to take you to My CareSource.
   - Click on the *Health tab* in the top navigation bar
   - Scroll to the *Assessment* section
   - Click on the Indiana Heath Needs Screening start button to answer the questions
3. **Mail:** Complete the printed copy of the HNS. You will get this in the mail after you get your new member booklet. Return it in the enclosed self-addressed postage paid envelope.
4. **Go to a Pursuant Health kiosk**. Kiosks are located in Indiana Walmart® pharmacies.

NOTE:

You must complete the HNS within 90 days of enrollment to be eligible to receive your $30 Walmart gift card. If you complete the HNS over the phone or by mail, you'll receive your gift card in the mail. If you complete your HNS online or at a Pursuant Health kiosk, you'll receive your gift card digitally.

MAKE THE MOST OF YOUR PLAN WITH THESE RESOURCES

CareSource Website

Our website provides quick access to a lot of your plan information.

Visit CareSource.com/IN to:

- See a list of covered benefits and services and how to use them.
- See the list of covered drugs.
- Use the Find a Doctor online tool to find a health care provider.
- Learn your rights and responsibilities.
- Access your secure My CareSource account.

Member Services

Member Services is open Monday - Friday from 8 a.m. to 8 p.m. Eastern Time except on holidays noted on the inside cover of this handbook.

Call Member Services for:

- Information about your benefits and plan.
- Help finding a doctor or other health care provider.
- Help with pharmacy/drug benefits.
- Choosing a drug/medicine.
- Finding out what is covered or if you need prior authorization. This means a pre-approval for a service.
- Getting a copy of your ID card.
- Getting to your **MyCareSource.com** account.

CareSource24 Nurse Advice Line

You can call any time to talk with a caring, skilled nurse. This is a free call. You can call **1-844-206-5947** (TTY: 1-800-743-3333 or 711) 24/7, 365 days a year (along with observed holidays).

Call the CareSource24 Nurse Advice Line to:

- Get help when you are sick.
- Find out how to care for an injury.
- Find out more about drugs or other medicines.
- Decide what kind of care you need.
- Get information about medical tests or surgery.
- Get help when you have after-hour non-traumatic dental concerns.
- Learn about healthy eating or wellness.

BEHAVIORAL HEALTH CRISIS LINE

We want to make sure you have help if you are going through a mental health or substance use crisis. Speak to a staff expert with behavioral health training at **1-833-227-3464**. You can call 24 hours a day, 7 days a week. You may also dial 988 to reach the 988 Suicide and Crisis Lifeline for any mental health concerns.

SCAN ME

Learn more about all of the behavioral health benefits we offer by scanning the QR code to this resource guide.

We are here to help you when you are going through a mental health or substance use crisis.

Give us a call if you are:

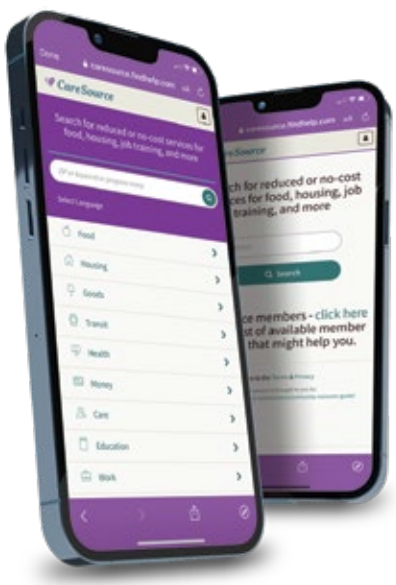
- Feeling hopeless
- Feeling anxious
- Feeling depressed
- Using or abusing drugs or alcohol
- Feeling overwhelmed
- Feeling alone
- Feeling like there is no reason for living
- Having dramatic mood changes

CARESOURCE MOBILE APP

This easy-to-use app lets you manage your CareSource health plan on-the-go. The app is free.

Use the CareSource Mobile App to:

- View your digital member ID card
- Choose to get information from us via email or text messages
- Find a health care provider, hospital, clinic or urgent care near you
- Learn more about your benefits
- View your claims
- Call and talk with Member Services
- Call the CareSource24 Nurse Advice Line to talk with a nurse 24/7/365
- Use tools like MyHealth and myStrength℠



WHERE TO GET CARE

 **Primary Medical Provider (PMP)**	Used for common sicknesses and tips. You will get most of your preventive care from your PMP. You should see your PMP the most often. This will help them get to know you and your health needs.
 **Telehealth**	Visit with a PMP by phone or computer. Ask them if they offer telehealth. If your PMP is not available or does not offer telehealth, you can use Teladoc®. Learn more at www.Teladoc.com/CareSource.
 **Mental Health and Other Providers**	Mental health providers offer services for people living with mental health and/or substance use problems. These providers are often the first place people go to get help for mental health and substance use issues.
 **Convenience Care Clinics**	Used for common sickness like coughs, colds, sore throats, and to get shots. They are found in many local drug and grocery stores, like CVS Minute Clinic® or Kroger Little Clinic®.
 **Urgent Care**	Used to treat non-life threatening issues. When you cannot visit your PMP, and your health issue cannot wait.
 **Hospital Emergency Rooms**	Use for life-threatening issues or emergencies. Call 911 or go to the nearest ER. If you are having a mental health emergency, call 988 for the Suicide and Crisis Lifeline.

YOUR PRIMARY MEDICAL PROVIDER (PMP)

Your PMP is your main doctor. They will work with you through all your medical care. PMPs in the CareSource network are trained:

- General Practitioners
- Internal Medicine Doctors
- Family Medicine Doctors
- Pediatricians
- Obstetricians
- Gynecologists
- Endocrinologists
- Nurse Practitioners
- Midwives
- Clinical Nurse Specialists
- Physician Assistants

PMPs can provide regular checkups, routine sick or well visits and immunizations (shots). Sometimes, your PMP is not able to treat your health needs. If they can't, they will send you to other health care providers (specialists). Your PMP will admit you to the hospital if needed. **Please call Member Services to let us know if you become pregnant. You should see your PMP within two weeks of finding out that you are pregnant.**

If you do not have a PMP we will choose one for you. We will choose a PMP for you based on:

- Where you live
- If the PMP is taking new patients

You can use the online Find a Doctor tool at **findadoctor.CareSource.com** to see the most current list of providers. You may also ask for a printed copy of a Provider Directory. Just send back the Provider Directory card in the New Member Booklet or call Member Services.

Choosing a New PMP

It is easy to choose a different PMP if you want one. Log into My CareSource®. This is your personal and secure online account at **MyCareSource.com**.

- Click on *Choose Provide*r
- Look up a health care provider
- Choose a provider and click on the *Select as Primary Care Physician* button

You can also choose a different PMP by calling Member Services. Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711). Have all your past health records sent to your new health care provider.

We will publish updates to our provider network no less than 30 days prior to the effective date of the change. To stay up to date, please review communications we send or post:

- In the mail
- On **CareSource.com**
- Through email or text
- In your My CareSource account

PRIMARY DENTAL PROVIDER (PDP)/DENTAL HOME

You should choose a PDP/Dental Home. A "Dental Home" is your dental office where you go regularly for care. Routine visits will help your provider know how to care for and support your dental health needs. They will help you maintain your dental health. Routine visits can help your dentist catch issues with your teeth, gums and other parts of your mouth or jaw early so they can be treated. You and each person in your family may also be eligible for a $20 reward. See page 41 to learn more.

If you don't choose a dental home, we will choose one for you. We will choose based on your history or family's history in our system, or we will assign a dentist near where you live. If you don't want to go to the dentist we assign you to, you can choose a dentist. You can get care from any network dental provider.

It's easy to choose your Dental Home. Log into My CareSource at **MyCareSource.com**. This is your personal, secure online account.

1. Click on *Choose Provider*
2. Look up a health care provider
3. Choose a provider and click on the *Select as Dental Provider/Dental Home* button

You can also choose a different PDP by calling Member Services. Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711). We are here to help. We are open 8 a.m. to 8 p.m., Monday through Friday, Eastern Time (ET).

See the rewards section below to learn more about how you can earn rewards for completing routine dental exams.

Telehealth

Telehealth is a convenient option for care. You can get quick medical advice that can prevent your condition from getting worse. Your PMP may offer this service on your phone or computer. You can talk to your PMP from wherever you are.

There is no extra cost to use telehealth. You also won't need transportation to and from your provider's office. You can use it for many common issues, such as:

- Cold and flu
- Sore throat
- Sinuses
- Allergies
- Pink eye
- Ear infections
- Urinary tract infections
- Rash and skin conditions

You can also use it for follow-up appointments. Your provider can tell you if telehealth is a good choice for you. They can also tell you when you need an in-person visit. Please check with your PMP to learn more.

You may use Teladoc® if your provider doesn't offer telehealth or has set hours. You may use Teladoc to speak to a board-certified doctor anywhere, 24/7. Learn more about Teladoc at www.Teladoc.com/CareSource.

Note: Telehealth should not be used for trauma, chest pain, shortness of breath or the prescribing of Drug Enforcement Agency (DEA) controlled substances.

Convenience Care Clinic

These clinics are open 7 days a week with evening and weekend hours. These clinics are a good option if your PMP is not available. Check your local drug store for clinics like Kroger Little Clinic® or CVS Minute Clinic®. Use these clinics for help with common illnesses such as:

- Coughs
- Sinus problems
- Colds and sore throats
- Shots
- And more

Urgent Care

Some Urgent Cares are open 7 days a week and on evenings and weekends. Use them for:

- Common illnesses
- X-rays
- Deep cuts
- When your PMP is not available and your condition or injury can't wait

Emergency Room (ER)

An emergency room (ER) is open 24/7/365. An ER is the best place to go for life threatening health issues. Examples are chest pain or head injuries. If you have an emergency, call 911.

If it's not an emergency, you can call the CareSource24 Nurse Advice Line at **1-844-206-5947** (TTY: 1-800-743-3333 or 711) if you need help. A nurse can tell you the best place to get care based on your health issue.

NOTE:

HIP members will need to pay an $8 copay to the hospital if they go to the ER for a non-emergency.

Follow-Up Care

You may need more care after your emergency. This is called follow-up care.

Let CareSource know that you have had an emergency. Tell your CareSource Care Manager if you have one. They can help you adjust back home and schedule follow-up visits. If you don't have a CareSource Care Manager, but want one, give us a call at **1-844-438-9498**.

We will talk to providers who give you care during your health issue. The providers will tell us when your medical emergency is over. They need to tell us if you need more care. Your health care provider can tell us by calling **1-844-607-2829** and asking for approval of these services. We will cover your follow-up care 24 hours a day, seven days a week. If your care was out-of-network, CareSource will find you in-network providers. They will take over your care as soon as possible.

UNSURE WHERE TO GO?

Unsure if you need to go to the emergency room (ER)? Call your PMP or CareSource24 at **1-844-206-5947** (TTY: 1-800-743-3333 or 711). Your PMP or the nurse can talk to you about your health problem. They can help you figure out next steps. You can also call CareSource24 for afterhours dental concerns or emergencies. Call your dentist office first and then the CareSource24 Nurse Advice Line if you are unsure if you need to go to the ER for a dental concern.

If you need the emergency room (ER)

Call 911 or go to the nearest ER if you are experiencing an emergency. Show your member ID card and tell the staff you are a CareSource member. If the health care provider treats your emergency, but recommends more treatment, they must call CareSource.

Call your PMP as soon as you can. Tell them of your health emergency and plan any follow-up services. If you must stay at the hospital, have the hospital call CareSource within 24 hours.

MEMBER BENEFITS

The two sections below will tell you more about your benefits.

- See **Hoosier Healthwise (HHW)** for more about HHW benefits.
- See **Healthy Indiana Plan (HIP)** for more about HIP benefits.

These sections tell you:

- What CareSource pays for
- What CareSource does not pay for
- What a medical necessity is, and if it changes how much we'll pay
- What services you need pre-approval (prior approval) for
- How much you will have to pay

Medicaid only covers medically necessary services. You get them at no cost to you unless your plan has copays. Medically necessary means you need the services to prevent, diagnose or treat a medical condition. You should not get a bill for these services. Please call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you get a bill.

Explanation of Benefits

We will send an Explanation of Benefits (EOB) when you visit a health care provider or get other health care services.

An EOB is not a bill. It will list:

- Who got care
- The health care provider who billed for the care
- The date of the care
- The type of care
- The amount CareSource paid
- How much you owe or already paid

Only members with copays will owe money for services. Providers can't charge you more than what we pay for a covered service. You will get a bill from the provider if you owe for a service. Please save your EOBs and pay only what the EOB shows you owe. Please call Member Services if you get a bill for more than what the EOB shows you owe or care you did not get.

Going Green

You can view your EOB online at any time. Just log in to your My CareSource account. No more waiting on the mail! No more piles of paper!

PRIOR AUTHORIZATION (PA)

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.

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.

CareSource will not cover some services or prescription drugs without a prior authorization. You can see these on the charts on the next pages. Please call us if a service you need is not in the charts.

Services that may need a prior authorization are:

- Prescription drugs
- Dental care such as some gum surgery and oral surgery, dentures, braces, anesthesia for adults and services performed in hospitals and ambulatory surgery centers
- Hospital care (except emergency room)
- Medical supplies and equipment
- Inpatient services for mental health or substance use disorder services
- Rehabilitation 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 (PA) – 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.

This is not a full list of services that need PA. There may also be differences between the HIP and HHW plans. You can go to **www.caresource.com/documents/in-med-prior-auth-list-mycaresource.pdf** to view the PA list.

Please see these handbook sections to learn more:

- **Hoosier Healthwise (HHW)**
- **Healthy Indiana Plan (HIP)**

Questions about prior authorization? Call Member Services or visit **CareSource.com/IN**.

Services Outside of Network

We can help if you can't get care you need in our network. We may work with an out-of-network provider to meet your needs. Please call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) for help.

Exclusions: Self-Referral Services	Requires PA for Out-of-Network Providers
Emergency Services	
Urgent Care Services	√
Family Planning	
Immunizations	√
Podiatry	√
Behavioral Health Services	√
Eye Care* (except surgery)	√
Diabetes Self-Management Training	√
Chiropractic Services*	√
Behavioral Health	√
Routine Dental Services*	√

**If covered under members' benefit plan.*

Continuity of Care

Are you new to CareSource? We will work with your current health care providers if you're a new member. Give us a call if you're getting care from a provider that you want to keep getting as a new member, but you're not sure if they are part of our network. We can work with you on a plan to help you keep getting care that you have in place.

Self-Referral Services

As a HIP or HHW member, the services listed below do not need a referral from your Primary Medical Provider. This means you can decide if you need these services and refer yourself for these kinds of services on your own.

Self-Referral Services	HIP	HHW
Emergency Services	√	√
Urgent Care Services	√	√
Family Planning	√	√
Immunizations	√	√
Podiatry	√	√
Psychiatric Services	√	√
Eye Care* (except surgery)	√	√
Diabetes Self-Management Training	√	√
Chiropractic Services*	√	√
Behavioral Health	√	√
Dental*	√	√

**If covered under members' benefit plan.*

For more information about referrals, please call Member Services.

HOOSIER HEALTHWISE (HHW)

WORDS TO KNOW IN THIS SECTION:
Income - This is the wages or earnings you earn yearly.
Copay - This is the amount you pay when you get a health care service.
Plan - This is the health coverage you get through CareSource

The HHW program covers children up to age 19 and some pregnant women. There is little or no cost for members. The plan covers:

- Doctor visits
- Dental care
- Family planning
- Prescription medicine
- Hospitalizations
- Immunizations (shots)
- Mental health care
- Surgeries

HHW Benefit Packages

The State will let you know if you are eligible for HHW. They will choose the right plan for you. If you are unsure which HHW plan you are in, call Member Services for help.

Package A: Standard Plan. Package A is a full-service plan for children and pregnant women.

Package C: Children's Health Insurance Program (CHIP). Package C is a full-service plan for children up to age 19. There is a small monthly payment and copay for some services. This is based on family income.

The State will send you an invoice for this amount. It is due by the date listed on the invoice. You must pay your premiums within 60 days from the due date. Otherwise, you may lose CHIP coverage.

You can make payments in these ways:

- By Mail: Package C Premium (make changes payable to "Children's Health Insurance")
  P.O. Box 3127
  Indianapolis, IN 46206-3127
- By Phone: 855-765-8672
- Online: https://53.billerdirectexpress.com/ebpp/hhwmwpremium/

You can make a payment with a credit card, debit card, or electronic check when you call or pay online. You will need your account number. It can be found on your monthly bill.

If you don't pay on time and lose CHIP coverage, you can reapply. You must pay all past due premiums and the current months premium when you reapply to be eligible. Health care services that you had during the time you lost coverage will not be covered.

You must let the State know about income or household changes. Go to the online benefits portal at www.fssabenefits.in.gov/bp/#/ to report changes. Or call **1-800-403-0864**.

HHW Benefit Summary

Below is a list of common services under each HHW Package. Please call Member Services if you do not see the service you need. Except for family planning or emergency services, out-of-network health care providers need prior authorization (also called pre-approval). Go to **CareSource.com** for more details on prior authorization.

Office Visits / Hospital Visits			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Doctor Visits	Yes	Yes	Prior authorization is generally not needed for these services. PA is needed for chiropractic after initial benefit is met. PA is needed for non-emergency hospital care. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Early and Periodic Screening, Diagnostic and Testing (EPSDT)	Yes	Yes	
Checkups	Yes	Yes	
Chiropractors	Yes	Yes	
Family Planning Services	Yes	Yes	

Office Visits / Hospital Visits			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Clinic Services	Yes	Yes	Prior authorization is generally not needed for these services. PA is needed for chiropractic after initial benefit is met. PA is needed for non-emergency hospital care. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Nurse Practitioner Services	Yes	Yes	
Urgent Care Services	Yes. Urgent Care services are covered if they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	Yes. Urgent Care services are covered if they are medically necessary. Urgent care is care needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	
Hospital Care (Non-Emergency)	Yes	Yes	

Pharmacy and Medicine			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Preferred Drug List Drugs	Yes	$3 copay generic, compound and sole source drugs. $10 copay brand-name drugs.	Prior authorization is needed for some drugs that require step therapy, quantity, or medical necessity. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Emergencies, Tests and Transportation			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Emergency Services	Yes	Yes	Prior authorization is not needed for most of these services. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Lab and X-ray Services	Yes	Yes	
Emergency Transportation	Yes	$10 copay for ambulance transportation	
Dental Benefits			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Oral Exams and X-Rays	Yes	Yes	Oral exams, x-rays and preventive services do not need prior authorization. Many of these other services do require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Dental Cleanings	Yes	Yes	
Other Preventive Services	Yes	Yes	
Minor Restorative Services (ex: Fillings)	Yes	Yes	
Major Restorative Services (ex: Dentures)	Yes	Yes	
Periodontal Services	Yes	Yes	
Extractions and Oral Surgery	Yes	Yes	
Orthodontics (ex: Medically necessary braces)	Yes	Yes	
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.			

Special Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Anesthesia (including dental)	Yes	Yes	Many of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Nursing Facility Services (Long Term)	Transition of Care up to 60 days.	No	
Skilled Nursing Facility Services (Short Term)	Yes, less than 30 days.	No	
Hospice Care	No*	No*	
Nurse Midwife Services	Yes	Yes	
Foot Care	Laboratory services, x-ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary. No more than six routine foot care visits per year are covered. Exceptions may apply.	Laboratory services, x-ray services, hospital stays and surgical procedures involving the foot are covered when medically necessary. Routine foot care services are not covered. Exceptions may apply.	
CareSource Life Services® and CareSource JobConnect, support programs for non-medical barriers	Yes	Yes	
Home Health Services	Yes	Yes	
Stop Tobacco Use *Quit Now Indiana* ***1-800-784-8669***	Yes	Yes	
Education/Training Services	Yes	Yes	
Non-Emergency Transportation	Yes	No	
DME/Orthotics/Prosthetics	Yes	Yes	

**Members requiring long-term care may qualify for Hospice benefits under Traditional Medicaid. For more information, please call Member Services.*

Mental Health and Substance Use Disorder Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Assessments, Screenings & Evaluations	Yes	Yes	Many of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Counseling	Yes	Yes	
Psychiatry	Yes	Yes	
Intensive Outpatient Treatment (IOT)	Yes	Yes	
Partial Hospitalization Program (PHP)	Yes	Yes	
Medication Assisted Treatment (MAT)	Yes	Yes	
Withdrawal Management	Yes	Yes	
Substance Use Disorder Residential Treatment	Yes	Yes	
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	

Therapies/Habilitative Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Applied Behavioral Analysis (for Autism Spectrum Disorder)	Yes	Yes	Some of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Speech Therapy	Yes	Yes	
Respiratory Therapy	Yes	Yes	
Occupational Therapy	Yes	Yes	
Physical Therapy	Yes	Yes	

CareSource Hoosier Healthwise (HHW) benefits are in agreement with the Indiana Health Coverage Programs requirements. Any updates to the benefits, how they are delivered, how they are authorized, or where the site of care will be posted will be no less than 30 days before the start date of the change. In order to stay current on benefit coverage and plan changes, CareSource members should read any communication sent in the mail, via email or text, posted on **CareSource.com** or on the member portal.

HEALTHY INDIANA PLAN (HIP)

WORDS TO KNOW IN THIS SECTION:

Income – This is the wages or earnings you earn yearly.

Plan – This is the health coverage you get through CareSource

The Healthy Indiana Plan (HIP) is an insurance program offered by the state of Indiana. HIP gives health care to low-income adults. Go to www.in.gov/fssa/hip to learn more about HIP income limits.

You must let the State know about income or household changes. Go to the online benefits portal at www.fssabenefits.in.gov/bp/#/ to report changes. Or call 1-800-403-0864.

HIP Benefit Packages

HIP General Information

HIP covers all basic health benefits. Some plans may have extra benefits, like dental and vision. HIP has a Personal Wellness and Responsibility (POWER) account.

You will use POWER Account funds to pay for the first $2,500 of care you get each year.

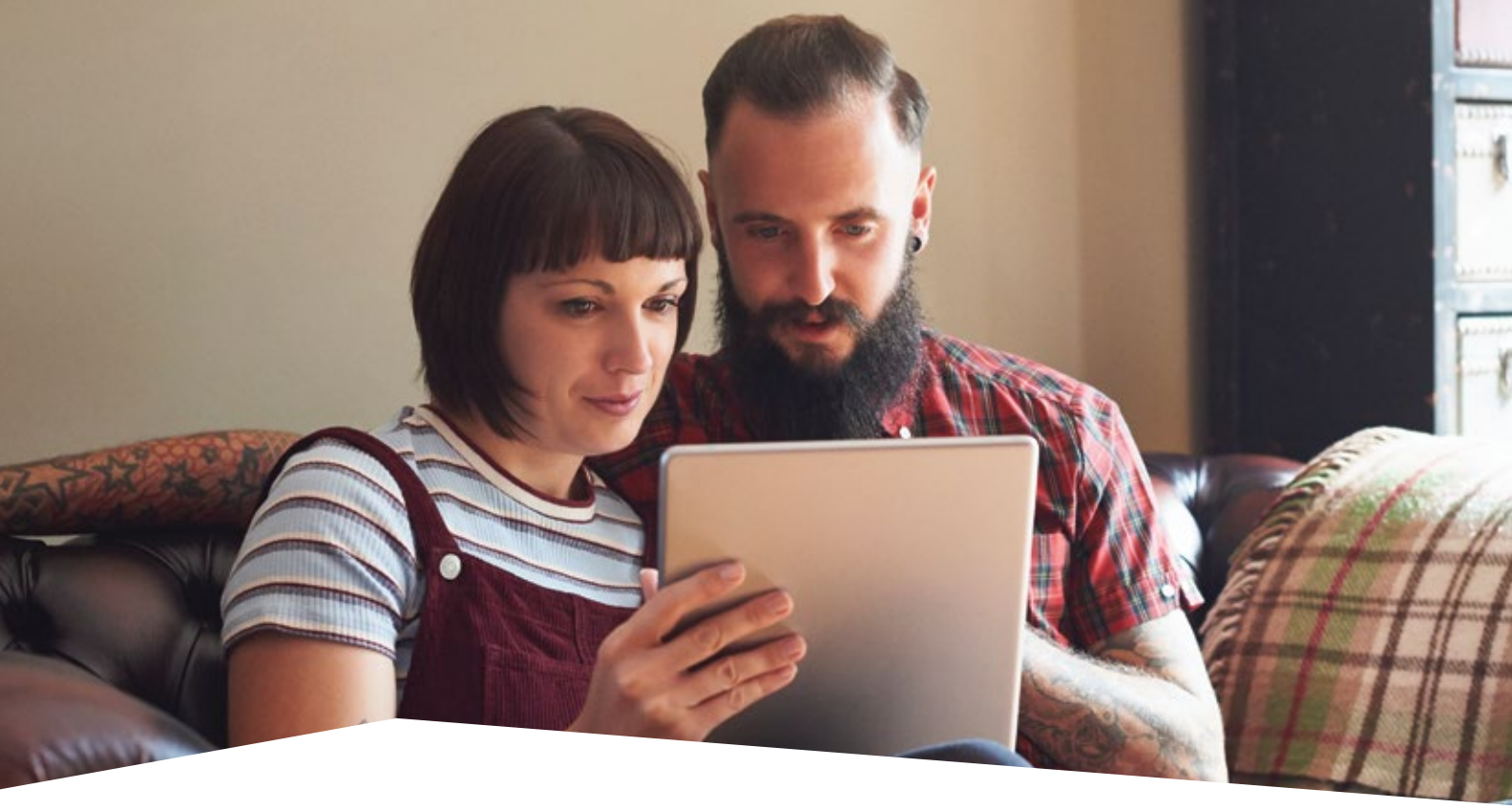
HIP Plus

- HIP Plus is the preferred plan. It covers all the key health benefits for a low monthly cost.
- It includes vision, dental and chiropractic services.
- It offers more physical, speech and occupational therapy visits than HIP Basic. There are extra services like bariatric surgery and jaw care (temporomandibular joint dysfunction or TMJ).
- You do not pay out of pocket for each visit or prescription.
- There are no copays in HIP Plus, except for $8 if you go to the ER for a non-emergency.

HIP Maternity

Let us know if you become pregnant to get HIP Maternity benefits.

- HIP Maternity offers current benefits plus additional benefits during the HIP member's pregnancy, and for an extra 12 months starting the last day of pregnancy. It includes vision, dental and chiropractic services at no cost.
- It covers non-emergency rides.
- HIP Maternity can help you find ways to stop tobacco use.



MEDICALLY FRAIL AND HIP BENEFITS

If you are a HIP member and qualify as medically frail, you have more benefits in the HIP State Plan. This will include benefits like dental and vision. You may be medically frail if you have one or more of these conditions:

- Disabling mental disorder
- Chronic substance use disorder
- Serious and complex medical conditions
- Physical, intellectual or developmental disability which greatly impairs your ability to perform one or more daily living activities (such as bathing, dressing or eating)
- Disability determination from the Social Security Administration

If we verify you are medically frail, you will get HIP State Plan benefits. We may check these conditions based on your claims (medical care you get). You may also call us at the number listed at the bottom of the page if you believe you may qualify as medically frail. Call us or go to www.in.gov/fssa/hip/am-i-eligible/conditions-that-may-qualify-you-as-medically-frail/ to learn more. You have the right to appeal if you do not agree with our decision.

HIP State Plan

HIP State Plan includes HIP State Plan Plus and HIP State Plan Basic. It is for those who need additional benefits. These benefits are for those with certain medical conditions that need more care or the State says are eligible.

HIP Benefit Summary

Below is a list of common services under each HIP Package. Please call Member Services if you do not see the service you need. With the exception of family planning or emergency services, out-of-network health care providers need prior authorization.

Office Visits/Hospital Visits						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Doctor Visits	Yes	Yes	Yes	Yes	Yes	Most of these services do not need prior authorization (except for non-emergency hospital care). Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Early and Periodic Screening, Diagnostic and Testing (EPSDT)	Yes, for ages up to 21.					
Checkups	Yes	Yes	Yes	Yes	Yes	
Chiropractic Manipulation	Yes, limit 6 per year.	No	Yes, limit 6 per year.	Yes, limit 6 per year.	Yes, limit 6 per year.	
Family Planning Services	Yes	Yes	Yes	Yes	Yes	
Clinic Services	Yes	Yes	Yes	Yes	Yes	
Nurse Practitioner Services	Yes	Yes	Yes	Yes	Yes	
Hospital Care (Non-emergency)	Yes	Yes	Yes	Yes	Yes	

Pharmacy and Medicine						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Preferred Drug List (PDL) Drugs	Yes	Yes	Yes	Yes	Yes	Prior authorization needed for some drugs for step therapy, quantity, or medical necessity. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Mail Order Prescriptions	Yes	Yes	Yes	Yes	Yes	
Emergencies, Tests and Transportation						
Emergency Services	Yes. If the service is not for an emergency the copay will be $8.	Yes. If the service is not for an emergency the copay will be $8.	Yes	Yes. If the service is not for an emergency the copay will be $8.	Yes. If the service is not for an emergency the copay will be $8.	Prior authorization is not needed for most of these services. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Lab and X-ray Services	Yes	Yes	Yes	Yes	Yes	
Emergency Transportation	Yes	Yes	Yes	Yes	Yes	

Mental Health and Substance Use Services						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Assessments, Screenings & Evaluations	Yes	Yes	Yes	Yes	Yes	Many of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Counseling	Yes	Yes	Yes	Yes	Yes	
Psychiatry	Yes	Yes	Yes	Yes	Yes	
Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes	Yes	Yes	
Partial Hospitaliza-tion Program (PHP)	Yes	Yes	Yes	Yes	Yes	
Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes	Yes	
Withdrawal Management	Yes	Yes	Yes	Yes	Yes	
Substance Use Disorder Residential Treatment	Yes	Yes	Yes	Yes	Yes	
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	Yes	Yes	Yes	

Dental Benefits						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Oral Exams and X-rays	Yes	HIP Basic members age 19- 20 are eligible for (EPSDT) services and some limited enhanced preventive and diagnostic dental services.	Yes	Yes	Yes	Oral exams, x-rays and preventive services do not need prior authorization. Many of these other services do require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Dental Cleanings	Yes		Yes	Yes	Yes	
Other Preventive Services	Yes		Yes	Yes	Yes	
Minor Restorative Services (ex: Fillings)	Yes		Yes	Yes	Yes	
Major Restorative Services (ex: Dentures)	Yes		Yes	Yes	Yes	
Periodontal Services	Yes		Yes	Yes	Yes	
Extractions and Oral Surgery	Yes		Yes	Yes	Yes	
Accident or Injury Related Dental Services	Yes	Yes	Yes	Yes	Yes	
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.						

Specialty Services						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Routine Foot Care	Yes, 6 visits per year.	Yes, 6 visits per year.	Yes, 6 visits per year.	Yes, 6 visits per year.	Yes, 6 visits per year.	Many of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Vision Care	Yes. One routine exam per year up to age 20. One routine exam every two years over age 20. One pair of glasses per year up to age 20. One pair of glasses every 5 years over age 20.	No (except for members 19 and 20 years old)	Yes. One routine exam per year up to age 20. One routine exam every two years over age 20. One pair of glasses per year up to age 20. One pair of glasses every 5 years over age 20.			
Skilled Nursing Facility Services	Yes, 100-day limit per benefit period.	Yes, 100-day limit per benefit period.	Yes, 100-day limit per benefit period.	Yes, 100-day limit per benefit period.	Yes, 100-day limit per benefit period.	
DME / Orthotics / Prosthetics	Yes	Yes *With Enhanced Benefits	Yes	Yes	Yes	
Home Health Services	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	
Hospice Care	Yes	Yes	Yes	Yes	Yes	

Specialty Services						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Medical Supplies and Equipment (e.g. hearing aids, prosthetic devices, etc.)	Yes	Yes	Yes	Yes	Yes	Many of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more. Prior authorization is not needed for NEMT
Education and Training Services	Yes	Yes	Yes	Yes	Yes	
Non-Emergency Transportation (NEMT) (e.g. medical visits, food, pharmacy)	Yes *Added CareSource Benefit	Yes *Added CareSource Benefit	Yes *With Enhanced Benefits	Yes	Yes	
Therapies / Rehabilitative Services 60 (Basic Plan) / 75 (Plus Plan) combined visits annually for physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehabilitation						
Rehabilitation Services	Yes	Yes	Yes	Yes	Yes	Some of these services require prior authorization. Call Member Services at **1-844-607-2829** (TTY: 711) to learn more.
Speech Therapy	Yes	Yes	Yes	Yes	Yes	
Occupational Therapy	Yes	Yes	Yes	Yes	Yes	
Physical Therapy	Yes	Yes	Yes	Yes	Yes	

CareSource Healthy Indiana Plan (HIP) follows the instructions of the Indiana Health Coverage Program. We will let you know at least 30 days before any changes are made to benefits, how they are offered or if prior authorization changes. All CareSource members should read anything sent in the mail, posted on **CareSource.com** or the member portal to check for any changes

SERVICES NOT COVERED

CareSource will not pay for some services or supplies. You must follow the rules in this handbook. This is not a full list of services that are not covered. Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you have questions about what is and is not covered.

- Abortions (except when as a result of a reported rape, by incest or is medically needed to save the mother's life)
- Acupuncture
- Services/care you have outside the USA
- All services or supplies that are not medically necessary
- Experimental services and procedures
- Alternative medicine
- Infertility treatments for males and/or females (This includes reversal of voluntary sterilization.)
- Plastic or cosmetic surgery that is not medically necessary
- Voluntary sterilization under age 21, or of a member who is legally incapable of consenting to the procedure
- Long-term care
- Waiver services—to learn more go to www.in.gov/Medicaid
- Private duty nursing
- Services provided by non-Indiana Health Coverage Programs (IHCP) enrolled health care providers

MENTAL HEALTH AND SUBSTANCE USE SERVICES

Behavioral health is a key part of your overall wellness. We can help if you are struggling with health concerns like depression, anxiety, or substance use and more. Call us or refer to your Provider Directory to find a provider. You can also use our Find a Doctor online tool at **findadoctor.CareSource.com**.

Need help now? Call the 988 Suicide and Crisis Lifeline at **9-8-8**. You can also call our Behavioral Health Crisis Line at **1-833-674-6437** (TTY: 711).

CareSource Addiction Support Line

We can help you find support in your recovery. Call our Addiction Support Line at **1-833-OPIOIDS (674-6437)**. It is OK to ask for help.

Opioid Treatment Programs

Opioid treatment programs (OTP) help people with opioid use disorder. They offer medication, medical and rehabilitative services. Doctors, nurses and counselors will work with you on your way to recovery. They can help you with your medications. OTPs also offer individual and group therapy. You do not need a referral or a prior authorization to choose an OTP and set up visits. The program must be in the CareSource network.

Here are the eligibility guidelines:

- **If you are 18 years of age and older,** you can apply for services if you have been struggling with addiction for one year or more.
- **If you are under 18 years of age,** you can apply if you have proof of two unsuccessful tries at short-term or drug free treatment within the past year.
- You just left prison and seek OTP services within 6 months of leaving
- You are pregnant
- You have been treated before and you seek treatment again within two years after leaving

You can find a list of opioid treatment programs on **Findadoctor.CareSource.com**. You can also call Member Services for help finding a program at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

Substance Use Disorder Residential Treatment Services

We are here to support you with Substance Use Disorder (SUD) residential treatment. These services need prior authorization. You can earn up to $100 in rewards for completing treatment. See page 42 to learn more.

SUD residential treatment can help you through your recovery with services such as:

- Withdrawal management (detox)
- Individual and group therapy
- Medication training and support
- Medication assisted treatment (MAT)
- Peer recovery support
- Case management
- And more

myStrength

Take charge of your mental health and try our online wellness tool called myStrength℠. This online learning platform has:

- Self-help tools
- Wellness help
- Inspirational quotes and articles

myStrength is a safe tool made just for you. It can help you with your mind, body and spirit. To sign up, create a profile, and learn more, go to **bh.mystrength.com/caresource**. You can also find myStrength at **MyCareSource.com** or download the free app on your mobile device. You can get the myStrength app for Apple or Android devices at **www.mystrength.com/mobile**. Sign in using your login email and password.

BeMe Health: Mental Health App for HHW Teens

BeMe is a safe and effective mobile app that helps teens through the ups and downs of being a teenager. We offer BeMe for Hoosier Healthwise teens ages 13-18. You can use it at no cost to you or your family. BeMe supports teens by helping them build healthy habits, develop communication skills, cope with stress, manage depression or anger and more. Teens have access to BeMe coaches 24/7 and they can connect them to therapy with providers in our network as needed.

BeMe is Safe and Private

BeMe is a safe and supportive space for teens. It's developed with experts, based in science, and meets high standards for privacy and security. It is not like social media. They never sell data and there are no ads.

Signing Up is Easy

Teens can download BeMe Health from the app store or visit **beme.com/caresource**.

Questions?

You can call us to learn more at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) Monday through Friday from 8 a.m. to 8 p.m. You can also call our Care Management team at **1-833-230-2039** Monday through Friday 8 a.m. to 5 p.m.

Therapies and Rehabilitative Services

Therapies and Rehabilitative Services help a person keep, learn, or improve skills for daily living. These services may include:

- Physical and occupational therapy
- Speech therapy
- Other health care services for people with disabilities in a variety of settings

Therapies/Habilitative Services		
Type of Service	**What It Is**	**Prior Authorization Needed?**
Applied Behavioral Analysis (for Autism Spectrum Disorder)	Help for children with autism spectrum disorder	Yes, prior authorization needed for all visits.
Education / Training Services	Services to help members manage their diabetes	Yes, prior authorization needed for all visits.
Speech Therapy	Services to help members manage their speech, hearing or language disorders	Yes, prior authorization needed for all visits.
Respiratory Therapy	Services to help members with problems related to breathing	Yes, prior authorization needed for all visits.

Therapies/Habilitative Services		
Type of Service	**What It Is**	**Prior Authorization Needed?**
Occupational Therapy	Services to help members improve fine and gross motor skills in daily activities to help regain independence	Yes, prior authorization needed for all visits.
Physical Therapy	To help members improve movement and manage pain	Yes, prior authorization needed for all visits.

Our benefits meet Indiana Health Coverage Program requirements. We will post plan updates no less than 30 days before the change start date. These updates may include:

- Benefit changes
- Delivery of benefits
- How we approve benefits
- Where the site of care will be

To stay current with these changes, you should read any communication:

- Sent in the mail
- Sent by email or text
- Posted on **CareSource.com** or on the member portal

TRANSPORTATION (RIDES)

You have ride benefits if you are in HIP or HHW Package A. You can also get mileage repayment. You can get rides for visits that are covered*. This means you can get a ride home from the hospital, a ride to urgent care, or a ride to see a doctor quickly. There are no limits on how many rides you can get for these visits. You also have non-emergency transportation if you are in HIP or HHW Package A for:

- Unlimited rides to the pharmacy after your visit with the doctor.
- Five trips per month to the pharmacy without having to see your provider first.
- Unlimited rides to the local Women, Infants and Children (WIC) office
- Unlimited rides to service redetermination appointments with the State
- Unlimited rides to CareSource events.
- A ride to a non-medical appointment if enrolled in CareSource Life Services program (12 round trips per year).
- Rides to pick up food from the food pantry or curb-side food pick up from a grocery store (limited to 5 food trips per month)
- A ride to and from the NICU for parents with an admitted child
- A bus pass where available

HHW Package C members are only eligible for non-emergency ambulance transport between medical facilities. An in-network provider must ask for this transport. It is a $10 copay.

**For example, HIP Basic members that do not have dental, vision or chiropractic coverage cannot get rides to those appointments.*

Want to set up a ride?

Please call **1-844-607-2829** (TTY: 1-800-743-3333 or 711) for a ride at least two business days before your visit. You can also ask other questions you have about ride benefits. Our ride benefit is through a vendor. You can also set up a trip online. Go to **www.lcptransportation.com**. You can also get mileage reimbursement through them. If you have an emergency, call 911 or go to the nearest ER.

Transportation Policy

Please read the list below. These rules will help make rides safer and quicker. If you have any issues or concerns with your scheduled ride, please call Member Services.

Rides should be easy and enjoyable. Your driver is trained to treat you with respect and to think of your needs. Please treat the driver in the way you wish to be treated. Please follow these steps:

- Call to set up a non-emergency ride two business days before your trip. (Saturday, Sunday and holidays are not business days).
- Be able to give the full address, phone number, and who you will be seeing at the doctor's office.
- Be at the pick-up address. Be there at the earliest time given to you by the transportation service.
- To cancel your ride, call at least two hours before your pick-up time.
- When your visit is finished, call the transportation company for your return trip.

No Shows

You need to be ready for your pickup. You should be there at the beginning of your pickup time. The transportation company can only wait 10 minutes before you are marked as a no show. Call the transportation vendor as soon as you can if you cannot keep your appointment.

What is a *No Show?*

- If you are not at the pick-up location
- If you cannot be seen at the pick-up location
- If you are not on-time at the pick-up location

The driver will wait 10 minutes, then leave. If you have any questions, please call Member Services at the number at the bottom of this page.

INCENTIVES AND REWARDS

Earn Rewards for Getting Healthier

CareSource has two programs to give you rewards. Earn rewards for going to your well-visits and other doctor visits and screenings. We want you to be as healthy as you can be!

CareSource MyKids

CareSource rewards your kids for completing wellness visits, dental exams, vaccines and more. The rewards your kids earn can be used to buy groceries, clothes, personal items, school supplies and more. The only way your child can earn rewards is to register today! Each child in your family needs to be registered separately to earn rewards.

Who can sign up? Sign up your kids, age newborn through 17 years old. If you're pregnant and 17 years old and under, you can sign up both you and your baby.

****Please note:**

Rewards card cannot be used to buy alcohol, tobacco, firearms, lottery tickets, gasoline or to pay for utilities. Other limits may apply.

Rewards may change. Rewards may vary by age, gender and health needs. If you are no longer a CareSource member you will lose your access to the Rewards Portal. Any unused rewards may be no longer available.

Any unused rewards will expire 1 year from the date they are added to the card.

Some healthy activities may not be covered by your plan. You will need to pay for any cost share from a visit not covered by your plan.

2025 CareSource MyKids Rewards* Summary		
Healthy Activity	**Who's Eligible**	**Rewards***
Six well-baby visits in 15 months	Newborn through 15 months	$15 per visit
Well-Child Visit: 16 months through 30 months	Children ages 16 months through 30 months	$10 Three times per calendar year
Well-Child Visit: 3 Years through 17 Years	Children ages 3 years through 17 years	$20 One time per calendar year
Well-Child Vaccinations (Dtap, IPV, MMR, and Varicella - given as a series)	Children ages 4 years through 6 years	$20 One time per calendar year
Well-Child Vaccination - Tdap	Children ages 11 years through 17 years	$10 One time per calendar year
Well-Child Vaccination - HPV Series (given as a series)	Children ages 9 years through 17 years	$30 One time per calendar year

2025 CareSource MyKids Rewards* Summary		
Healthy Activity	**Who's Eligible**	**Rewards***
Well-Child Vaccinations - Meningococcal	Children ages 11 years through 17 years	$10 One time per calendar year
Yearly Flu Shot	Children ages 16 months through 17 years	$10 One time per calendar year
Health Needs Screening (HNS)	New members within 90-days of joining	$30 Walmart gift card
Routine Dental Exam	Children ages 16 months through 17 years	$20 One time per calendar year
Lead screening	Newborn through 15 months	$20 One time
Lead Screening	Children ages 16 months to 6 years	$20 One time per calendar year AND two times per lifetime
ADHD Follow-up Visits within 30 days of Initial Prescription	Children ages 16 months through 17 years diagnosed with ADHD	$10 One time per calendar year
ADHD Follow-up Visits within 10 months of initial prescription	Children ages 16 months through 17 years diagnosed with ADHD	$10 Two times per calendar year
Comprehensive Prenatal Risk Assessment	Pregnant women	$25 One time per calendar year
Prenatal Visits	Pregnant women	1st visit -$50 5th visit $25
Postpartum Visit	Postpartum women	$40 One time per pregnancy
Additional Postpartum Visit	Postpartum women	$15 One time per pregnancy

How to Get Your Rewards

1. Sign up for CareSource MyKids at **CareSource.com/Indiana** and click on Rewards. We will mail your CareSource Rewards Card after you do your first healthy activity.
2. After you get your CareSource Rewards Card, call 1-833-832-7306 (TTY: 711) or visit HealthyBenefitsPlus.com/CareSourceMDC. You will need your Rewards and member ID card to sign up.
3. Rewards are added to your card as you do healthy activities. When you see a provider, they will let us know. We will add the rewards to your account after we go through what they send us. This can take up to 60 days.
4. CareSource Rewards Card can be used at stores like:
   - CVS
   - Kroger
   - Walmart

- Dollar General
- Walgreens
- And many more

5. Buy health and well-being items with your CareSource Rewards Card. These can be:
   - Groceries
   - School items
   - Clothes
   - Diapers
   - And more!

** Rewards may change. Rewards may vary by gender, age, and health needs. If you are no longer a member your account will no longer be active. Your account will be deactivated, and any unused rewards may no longer be available. Rewards expire one year from the date of issue. You cannot buy tobacco, firearms, lottery tickets or utilities with your rewards card.*

MyHealth Rewards for Adults

Adults 18 years and older are part of MyHealth Rewards. The steps and charts below tell you about your MyHealth Rewards. They will tell you what you can earn and how to access your account.

Reward Amount up to $300.

How to Use MyHealth Rewards

1. Adults are part of MyHealth Rewards.
2. Log into **MyCareSource.com**. Click on the MyHealth Rewards link under the Health tab.
3. Rewards are added to your account as you do healthy activities. When you see a provider, they will let us know. We will add rewards to your account after we go through what they send us. This can take up to 60 days.
4. You can track your rewards and progress.
5. Get rewards for gift cards from:
   - Dominos®
   - Marshalls®
   - Sephora®
   - Google Play®
   - Old Navy®
   - TJ Maxx®
   - HomeGoods®
   - Panera®
   - Walmart®

Start Earning Rewards Today!

Questions? Call us at **1-844-607-2829** (TTY: 711) or visit **CareSource.com/Indiana** and click on *Rewards*.

**Rewards may change. Rewards may vary by gender, age, and health needs. If you are no longer a member your account will no longer be active. Your account will be deactivated, and any unused rewards may no longer be available. Rewards expire one year from the date of issue. You cannot buy tobacco, firearms, lottery tickets or utilities with your rewards card.*

2025 MyHealth Wellness and Preventive Rewards* Summary		
Healthy Activity	**Who Is Eligible**	**Rewards***
Yearly Physical Exam	All adults ages 18 through 64	$20 One time per calendar year
Yearly Dental Exam	All adults ages 18 through 64	$20 One time per calendar year
Yearly Flu Shot	All adults ages 18 through 64	$10 One time per calendar year
Indiana Health Needs Screening Completion	All adult new members within 90 days of eligibility Ages 18 through 64	$30 Walmart® gift card. See Step 8 in the Quick Start Guide for details on how to complete the Health Needs Screening. Must be completed within first 90 days of enrollment.
Breast Cancer Screening (Mammogram)	Women ages 50 through 64	$20 One time per calendar year
Chlamydia Screening	Women ages 18 through 25	$10 One time per calendar year
Cholesterol Screening	Males ages 35 through 64 Females ages 45 through 64	$10 One time per calendar year
Cervical Cancer Screening (Pap Smear)	Women ages 18 through 64	$10 One time per calendar year
Complete a Journey in MyHealth	All adults ages 18 through 64	$5 Two times per calendar year
HPV Vaccine (given as a series)	Adults 18 through 26	$10 for the series
Pneumococcal Vaccine	All adults ages 18 through 64	$10 One time per calendar year
Comprehensive Prenatal Risk Assessment	Pregnant adults ages 18 through 64	$25 One time per calendar year
Vaccination - Tetanus-Diphtheria Booster	All adults ages 18 through 64	$10 One time per calendar year

Rewards for Pregnant Adults		
Healthy Activity	**Who Is Eligible**	**Rewards***
Prenatal 1st Visit	Pregnant adults ages 18 through 64	$50 One time per calendar year
Prenatal 5th Visit	Pregnant adults ages 18 through 64	$25 One time per calendar year
Postpartum (After Baby) Visit	Pregnant adults ages 18 through 64	$40 One time per calendar year
Additional Postpartum Visit	Pregnant adults ages 18 through 64	$15 One time per calendar year

**Rewards may change. Rewards may vary by gender, age, and health needs. You will not be able to get into the Rewards Portal if you are no longer a CareSource member. Your account will be deactivated, and any unused rewards may no longer be available.*

2025 Chronic Disease Management Rewards Members can earn up to $200 in Chronic Disease Management rewards for Diabetes Testing.		
Healthy Activity	**Who's Eligible**	**Rewards***
ADHD Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with ADHD	$45 One time per calendar year
Asthma Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with asthma	$15 Four times per calendar year
CAD Beta-blocker Adherence Post AMI or Other Cardiac Event	All HIP and HHW adults ages 18+ diagnosed with CAD	$25 One time per calendar year
CAD and DM Statin Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with CAD	$45 One time per calendar year
CHF Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with CHF	$45 One time per calendar year
Comprehensive Prenatal Risk Assessment	All HIP and HHW adult pregnant females ages 18+	$25 One time per calendar year
COPD Corticosteroid Adherence Post-Acute Care Event	All HIP and HHW adults ages 18+ diagnosed with COPD	$15 One time per calendar year
COPD Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with COPD	$45 One time per calendar year

2025 Chronic Disease Management Rewards		
Healthy Activity	**Who's Eligible**	**Rewards***
Depression (Major), Bipolar Disorder, or Schizophrenia Disorder 7-Day Follow-up Appointment After Hospital Discharge	All HIP and HHW adults ages 18+ diagnosed with depression	$40 Two times per calendar year
Depression (Major), Bipolar Disorder, or Schizophrenia Disorder Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with depression	$45 One time per calendar year
Diabetes Medication (all classes) Adherence	All HIP and HHW adults ages 18+ diagnosed with diabetes	$45 One time per calendar year
Diabetes A1C Testing	All adults ages 18+ diagnosed with diabetes	$25 One time per calendar year
Diabetes Micro-Albumin Testing	All adults ages 18+ diagnosed with diabetes	$25 One time per calendar year
Diabetes Retinal Eye Exam	All adults ages 18+ diagnosed with diabetes *Exam must be performed by a specialty eye care provider.*	$25 One time per calendar year
Hepatitis C Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with Hep C	$45 One time per calendar year
HIV Medication Adherence	All HIP and HHW adults ages 18+ diagnosed with HIV	$15 Four times per calendar year
HIV Viral Load Test	All HIP and HHW adults ages 18+ diagnosed with HIV	$10 One time per calendar year

2025 Chronic Disease Management Rewards		
Healthy Activity	**Who's Eligible**	**Rewards***
Initiation of Care Management	All HIP and HHW adults ages 18+	$25 One time per calendar year
Completion of Care Plan (Goals Met)	All HIP and HHW adults ages 18+ Must have qualifying health needs classification.	$40 One time per calendar year

**Rewards may change. Rewards may vary by gender, age, and health needs. You will not be able to get into the Rewards Portal if you are no longer a CareSource member. Your account will be deactivated, and any unused rewards may no longer be available. Rewards expire one year from the date of issue.*

2025 Tobacco Cessation and Substance Use Rewards* Members can earn up to $200 in Tobacco Cessation and Substance Use Rewards		
Healthy Activity	**Who's Eligible**	**Rewards***
IN Tobacco Quitline Engagement in Cessation Coaching	All HIP and HHW adults ages 18+	$50 One time per calendar year
IN Tobacco Quitline Engagement in Cessation Coaching While Pregnant	All HIP and HHW adults ages 18+ who are pregnant	$50 One time per calendar year
IN Tobacco Quitline Program Completion	All HIP and HHW adults ages 18+	$80 One time per calendar year
Behavioral Counseling Initiation for Tobacco Cessation	All HIP and HHW adults ages 18+	$30 One time per calendar year
Pharmacologic Therapy upon Initiation of Tobacco Cessation	All HIP and HHW adults ages 18+	$30 One time per calendar year
Pharmacologic Therapy Completion of 12 Weeks for Tobacco Cessation	All HIP and HHW adults ages 18+	$40 One time per calendar year
Substance Use Disorder (SUD) Intensive Outpatient Treatment (IOT) Session	All HIP and HHW adults ages 18+	$10 Ten times per calendar year

**Rewards may change. Rewards may vary by gender, age, and health needs. You will not be able to get into the Rewards Portal if you are no longer a CareSource member. Your account will be deactivated, and any unused rewards may no longer be available. Your MyHealth Rewards expire in December of the following year. EX: Any unused 2024 rewards will expire mid-December 2025.*

PHARMACY/PRESCRIPTION DRUGS

CareSource RXInnovations™ partners with Express Scripts to help you manage your prescriptions and save money. We have online tools that list which medicines and pharmacies are covered under your plan. Visit **CareSource.com** and go to Find My Prescriptions and Find a Pharmacy to learn more.

- **Find My Prescriptions** lets you enter the name of your drug. It will tell you if it is covered.
- **Find A Pharmacy** lets you find a pharmacy near you in the CareSource network.

We will pay for your prescription drugs and some prescription medical supplies at the pharmacy. Some examples are:

- Diabetic Supplies
- Peak Flow Meters
- Needles
- Condoms
- Inhaler Spacers
- Syringes
- Alcohol Wipes

You will need to get your prescription drugs at a pharmacy that takes CareSource insurance.

WORDS TO KNOW:

- **Preferred Drug List (PDL):** A list of drugs that we like our providers to prescribe.
- **Prior Authorization:** When we pre-approve a health care service or medication that your doctor asks for before you get it.

You may qualify for medication adherence rewards. See page 44-45 for details about these rewards.

Preferred Drug List (PDL)

CareSource covers all medically necessary Medicaid-covered drugs at many pharmacies. We also cover many often used over-the-counter (OTC) products with a written prescription from your health care provider. We have a list of drugs that we like our providers to prescribe. This is called a Preferred Drug List (PDL). It includes products on Indiana Medicaid's Statewide Uniform Preferred Drug List (SUPDL).

Our drug list will have more than one drug for treating a condition. These are called alternative drugs.

You can find our PDL at **www.caresource.com/in/plans/medicaid/benefits-services/pharmacy/preferred-drug-list/**. Ask Member Services for a copy of our PDL and drugs that need prior authorization. Our PDL and drug list that need prior authorization can change monthly. Check this list when you need to fill or refill a prescription drug.

Pharmacy Programs

We have programs that make sure you get drugs that are safe and effective. These are:

- Step Therapy
- Generic Substitution
- Medication Therapy Management

Learn more about each of these programs on the following pages.

Step Therapy

Sometimes, we have you try a cheaper medicine used for the same condition before *stepping up* to a prescription drug that costs more. This is called step therapy. Certain drugs may only be covered if step therapy is used first.

Generic Substitution

A pharmacy will provide a generic drug if they have it in place of a brand-name drug. This is called generic substitution. You can expect the generic substitution to have the same effect and safety profile as the brand-name drug. Your provider should ask for a prior authorization if there is a generic equivalent available.

Medication Therapy Management (MTM) Program

Correct prescription drug use is key for your health. Medication Therapy Management (MTM) is a program for you to learn about your drugs. You get this service at no cost to you. MTM can help stop drug-related problems and may lower costs. It can help you stick to your plan and ensure you are taking your drugs the right way. This service is at no cost to you.

You can work with a local pharmacist or a CareSource pharmacist for MTM. If they think you need help, you can meet face to face with them or talk about your medications on the phone. They will take time to go over all your drugs. This is any pills, creams, eye drops, herbals or over the counter (OTC) items.

MTM Benefits

- Safe use of prescription drugs
- Helps your health care providers and other caregivers work well together
- Teaches you about your prescription drugs and how to use them
- Improves health

Prescription Prior Authorization

We may need to review and approve some drugs before they are covered. This is called a prior authorization (PA). Your provider will tell us why you need a certain prescription drug and/or a certain amount of a drug. Here are some reasons a PA may be needed:

- The drug could have dangerous side effects.
- There is a generic or **preferred** alternative drug available.
- The drug could be misused/abused.
- There are other drugs that **should** be tried first.

You can see on the PDL posted online which drugs need PA. You can also call us to ask about our PDL, and which drugs or services need PA.

Therapeutic Interchange

Sometimes you can't take a certain drug, like if you have an allergy. Other times, a drug might not work for you. In these cases, your provider can ask CareSource to cover a drug that is not on the approved drug list.

Exceptions

You may ask us to cover a drug not on the PDL. This is called an exception. You or a person allowed to represent you can make this request. Once we get this request, we will work with your provider to get the forms and information needed.

You may ask for an exception for:

- A drug you need that is not part of your covered health plan subject to medical necessity review by CareSource
- An allergy to a drug
- If you are unable to take a drug
- If you have a bad reaction to a drug listed on the PDL

We will send you information if we do not approve your request which will cover:

- How you can appeal the decision
- Information on your right to a State Hearing

Medication Disposal

Do you have out of date drugs you no longer use? Expired or unused drugs can be a health risk for toddlers, teens or family pets if they are within reach. It is vital to safely dispose of these drugs before they cause harm.

You can safely get rid of out of date or unused drugs at drug take back sites like local drugstores or police stations. Visit **www.deadiversion.usdoj.gov/pubdispsearch** to see a list of sites near you.

CareSource also has free DisposeRx® packets to help you safely get rid of these drugs. Get your free packet at **secureforms.CareSource.com/DisposeRx** or call Member Services.

CARE MANAGEMENT

Did you know you can also earn rewards for doing activities to help you stay healthy? You may earn up to $65 in rewards for actively taking part in Care Management. Go to the rewards section of this handbook to learn more.

Our Care Managers can help you better understand your health and help support you in your health journey. We have Care Management for children and adults. The Care Management team has nurses, behavioral health experts, and other outreach workers. If you ask, they can meet with you in person to listen to your concerns. They can help you find a health care provider and set up appointments. They can also help you find local resources and support. We also offer High Risk Care Management for complex health needs.

A Care Manager may contact you when:

- You ask them to. You can also call Member Services and ask for Care Management.
- Your health care provider asks CareSource to
- Care Management services may be helpful to you or your family
- You have a high-risk health issue and may need complex help
- You visit the ER
- You are pregnant
- You request help with pain

Conditions Care Management Can Help You With

- Substance Use Disorder (SUD)
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism/Pervasive Development Disorder (PDD)
- Chronic Kidney Disease (CKD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Coronary Artery Disease (CAD)
- Depression
- Diabetes
- Hepatitis C
- Human Immunodeficiency Virus (HIV)
- Hypertension
- Sickle Cell Disease (SCD)
- Other chronic conditions
- Pregnancy

Coordination of Care

Care Managers make sure your PMP and other health care providers are working together. This is called **coordination of care**. They will know if you need a PMP, specialist, urgent care, or the ER. Call **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you have questions or think you may need help. We are happy to help you.

Indiana Pregnancy Promise Program

The Indiana Pregnancy Promise Program is a free program. It is for pregnant Medicaid members who use opioids or have used opioids in the past. The program can link you to both prenatal and postpartum care. It can also help you find other physical and mental health care and treatment for opioid use disorder. The program offers support during the prenatal period and for 12 months after the end of pregnancy. It also has childcare benefits for those who join. You can join this free program here: https://appengine.egov.com/apps/in/promise. You can also earn up to $100 in rewards for taking part in this program.

Healthy Activity	Who's Eligible	Rewards*
Indiana Pregnancy Promise Program Initial Call	Program members who are pregnant	$25 1x per pregnancy
Indiana Pregnancy Promise Program Follow-Up Call	Program members who are pregnant	$25 1x per pregnancy
Indiana Pregnancy Promise Program Postpartum (After baby) Contact	Program members who are pregnant	$25 1x per pregnancy
Indiana Pregnancy Promise Program 6-12 months	Program members who are pregnant	$25 1x per pregnancy

Right Choices Program (RCP)

The Right Choices Program (RCP) is a state program. If you are in the RCP, you will get a letter that tells you about the program. You will have one primary medical provider and one pharmacy. You must see these providers unless you have an emergency. If you are in RCP, you have a CareSource Care Manager assigned to you. They will help you manage your care and make sure your needs are being met. Call your Care Manager with any questions.

Care Transitions

CareSource helps when you leave the hospital by:

- Answering questions
- Helping with your medicine
- Helping to arrange your PMP and/or specialist visits
- Helping you or your family with needs at home

If you or someone in your family needs help when they leave the hospital, call **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

Care Management Member Assistance Program

If you are working with the Care Management team you may have access to the member assistance program. This program has a fund that can help you remove barriers that prevent you from working and/or meeting your basic needs. We will try to find resources in the community for your needs before you can use the fund. Your Care Manager will fill out an application for approval to use the fund. The benefit limit is $200 per year (Jan-Dec). Areas of support may be:

- Transportation (separate from our general ride benefits)
- Clothing
- Work related expenses
- Housing and utility assistance (if not available where you are)
- Equipment for the home and food

DISEASE MANAGEMENT

We know that living with a health condition like asthma, diabetes and others, is hard. We offer free disease management programs to help you learn about your health. They can show you how to better manage your specific health conditions. Our goal is to make sure you have the right tools to stay as healthy as possible. We help our members through:

- The free MyHealth online wellness program. It has health education tools to help you meet your health goals. This program is for members 18 years and older. Go to **MyCareSource.com** and go to the *Health* tab to get to MyHealth.
- Material that teaches skills to help you self-manage the condition(s)
- Care Coordination with outreach teams

Your health care provider, pharmacy or other health care source may let us know that you would benefit from a program. We will send you materials related to your health condition. These tips and resources can help you self-manage your condition.

All ages (children, teens and adults) can take part in the program. You may also be able to earn rewards for sticking to your medication adherence plan. See page 40 to learn more about rewards. Members may self-refer or be referred into a program. They will get condition-specific information. Call us if you want to learn more about your health condition or to be part of a program. You can reach us at **1-844-438-9498**.

Weight Management Programs

FREE Health Coaching Programs
Did you know we offer two free health coaching programs for our HIP/HHW members? The programs are Healthy Body, Healthy Me for adults 18+ and Kids Wellness, for children 17 and under.

These programs can help you and your children adapt healthy habits so you can become healthier as a family. As part of these 12-month coaching programs, you and/or child will have one-on-one phone calls with a CareSource health coach. They can help you reflect on your overall health and steps you need to take to improve it. Both programs help you with:

- Physical Activity
- Healthy Eating
- Mental Health
- And More!

Want to learn more about or join either of these programs?
Call us at 317-982-6506. A health coach will ask you a few questions to learn more about you and/or your child. These questions help ensure the programs are a good fit for your family.

Preventive Care: Children and Adults

Your Primary Medical Provider (PMP) is an important partner in your preventive care.

What is preventive care? These are health tests and services that help keep you well. Routine visits and tests can help your provider find and treat problems. This helps you and your provider find problems before they become serious.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for Children: Birth to Age 21

EPSDT is a federal program. It is for babies, kids, and young adults. EPSDT is covered for HIP and HHW members birth to age 21.

EPSDT exams are to make sure children are healthy and growing physically and mentally. They cover medical exams, immunizations (shots), health education, and lab tests. They should have exams at ages:

Birth	3-5 days	1 month	2 months	4 months	6 months	9 months

12 months	15 months	18 months	24 months	30 months	36 months

After 36 months, EPSDT covers a well-child exam once a year. Each year up to age 21.

- EPSDT covers medical care for problems found by an exam. EPSDT visits are at no cost to you. Full medical exams (with a review of physical and mental health development).
- Vision exams
- Dental exams
- Hearing exams
- Developmental screenings
- Lab tests for certain ages, such as blood lead tests
- Immunizations (shots). Ask your doctor to learn more about what is appropriate for your child's age.
- Medical follow-up care to treat health issues
- Blood lead tests
- Children in HHW get a blood lead test by 12 months and again by 24 months old or earlier if at high risk for lead exposure

All children who are in HIP or HHW are required to get blood lead tests. Your doctor may decide if a test should be done earlier. Children between the ages of 24 months and 72 months must get a blood lead test if they have not been tested for lead poisoning before.

Schedule EPSDT visits for your child so your PMP/PDP can find any health problems early. Your PMP will send your child to a specialist if they need more care.

Some services may need your PMP/PDP to get a prior authorization (pre-approval). Your PMP/PDP may ask for a pre-approval from CareSource. This is for services with limits or that are not covered for members through age 20. Please see the **Prior Authorization** section of this handbook to learn more.

Rewards for Preventive Care

You can earn rewards for getting certain types of preventive care. Go to the Rewards section of this handbook on page 40 to learn more.

Preventive Care for Adults

There are many health activities you can do to help you stay well. The charts on the next page let you know what care you may need at what age. The charts are a guide. Make sure to ask your health care provider what health visits and tests you may need.

Words to know– preventive health activities:

- **Yearly Physical Exam:** A health care provider visit at least once a year. Do this even if you feel healthy.
- **Cholesterol Screen:** Get your cholesterol checked starting at age 20. If your level is within normal limits, get checked every five years. Your health care provider may check your cholesterol more if your level is not normal. You may be checked more if you have diabetes, heart disease, or kidney problems, or are taking certain medications. You could be screened more if you see changes in your weight or what you eat.
- **Diabetes Screen:** You should be screened for diabetes no later than age 45. Your health care provider may screen you at a younger age if you are overweight or have high blood pressure.
- **Dental Cleaning:** Have a dental professional clean your teeth at least twice a year.
- **Dental Exam:** Have a dentist look at all your teeth at least twice a year.
- **Eye Exam:** Get your eyes checked once every two years. If you have diabetes, it is vital to have an eye exam every year. Ask your health care provider if you need your eyes checked more often.
- **Chlamydia:** Women age 16-24, or older if at increased risk, should be screened for chlamydia each year.
- **Cervical Cancer Screen:** Women 21-65 should get a cervical cancer screening, called a pap smear, every 3 years.
- **Breast Cancer Screen:** Women between the ages of 40 to 74 should get mammograms. This is an x-ray of the breasts to help find cancer. This test should be done at least once every two years.
- **Colon Cancer Screen:** All people between ages 45 and 75 should get screened for colorectal cancer. You should talk with your health care provider about the test that is best for you. You may be tested at a younger age if you have a family history of colorectal cancer. There are many different tests to screen for colorectal cancer, talk with your provider about the test that is best for you.
- **Flu Shot:** Most adults should get the flu shot each year.
- **HIV Testing:** Recommended by the CDC for all patients between ages 13 and 64 at least once. Patients with ongoing risk factors should be tested yearly.
- **Pneumococcal Vaccine:** Adults 65 or older should get the vaccine. Health care providers may also suggest it for people younger than 65 who have certain other health problems.
- **Shingles Vaccine:** This is a vaccine that protects you against a painful disease caused by the chicken pox virus. Those with weak immune systems should not get it. Doctors may not suggest it for people over age 60.
- **Td Vaccine:** Adults should get a Td booster once every 10 years.
- **Tdap Vaccine:** Pregnant women should get this vaccine each time they are pregnant.

Preventive Care Guide for Women

Recommended Activities	20s	30s	40s	50s	60 & Older
Yearly Physical Exam	✔	✔	✔	✔	✔
Cholesterol Screen	✔	✔	✔	✔	✔
Diabetes Screen			✔	✔	✔
Dental Exam	✔	✔	✔	✔	✔
Eye Exam (HIP Plus only)	✔	✔	✔	✔	✔
Cervical Cancer Screen	✔	✔	✔	✔	✔
Breast Cancer Screen			✔	✔	✔
Colon Cancer Screen			✔	✔	✔
Flu Shot	✔	✔	✔	✔	✔
Pneumococcal Vaccine					✔
Shingles Vaccine				✔	✔
Td Vaccine	✔	✔	✔	✔	✔
Chlamydia Screen	Under 25 or older if at increased risk				

Preventive Care Guide for Men

Recommended Activities	20s	30s	40s	50s	60 & Older
Yearly Physical Exam	✔	✔	✔	✔	✔
Cholesterol Screen	✔	✔	✔	✔	✔
Diabetes Screen			✔	✔	✔
Dental Exam	✔	✔	✔	✔	✔
Eye Exam (HIP Plus only)	✔	✔	✔	✔	✔
Colon Cancer Screen			✔	✔	✔
Flu Shot	✔	✔	✔	✔	✔
Pneumococcal Vaccine					✔
Shingles Vaccine				✔	✔
Td Vaccine	✔	✔	✔	✔	✔

We can help if you have any questions about your preventive care needs. Take a Health Needs Screening (HNS). This will help us plan for you to reach your best health. There are three ways you can take the HNS:

- Over the phone by calling **1-833-230-2011** Monday - Friday between 7 a.m. to 6 p.m. Eastern Time.
- Online by signing into **MyCareSource.com** and clicking on the MyHealth link.
- Visit your local Walmart® pharmacy to use the health kiosk.

FAMILY PLANNING AND MATERNITY

Family Planning

We want you to have a healthy pregnancy. We offer family planning services that will help you to:

- Be at your healthiest before you become pregnant
- Make sure you do not have a baby until you are ready
- Make sure you or your partner protect against:
  - Sexually Transmitted Diseases
  - Sexually Transmitted Infections

You can go to any family planning provider. You do not need our approval before going. You can go to clinics, certified nurse-midwives, OB/GYNs and PMPs.

Maternity Benefits

Pregnant women in HIP and HHW will get the same added benefits. The State will assign you to HIP or HHW based on income level. Follow these steps to get all your extra pregnancy benefits:

Step 1: Report your pregnancy to us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) or call your local Division of Family Resources (DFR) at 1-800-403-0864.

Step 2: You will get HIP Maternity benefits after you tell us you are pregnant. HIP Maternity covers more benefits during your pregnancy and for 12 months postpartum (after baby). This postpartum time starts the last day of pregnancy. These benefits include current benefits plus:

- Vision
- Chiropractic services
- Dental services
- Non-emergency transportation
- Enhanced smoking cessation services for pregnant women

Step 3: Call your provider. You should see your provider in the first 3 months (12 weeks) of your pregnancy. This is called the first trimester. You should see your provider at least each month for the first and second trimesters. You will see them more often during the last trimester. This can help spot any problems before they become serious and avoid problems during birth.

If you need a provider you can go to our Find a Doctor link to look. Go to **findadoctor.CareSource.com**. You can also call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) for help.

Step 4: It's important to see your provider after you have your baby. These checks are covered as a part of your benefits.

Tell us when you have your child or your pregnancy has ended. Call us at **1-844-607-282**9 (TTY: 1-800-743-3333 or 711). Or call your local Division of Family Resources (DFR) at 1-800-403-0864. These benefits keep going for 12 months after the end of your pregnancy. Please call us if you have any questions.

Step 5: After the 12 month postpartum period you may move off HIP Maternity. You can move to HIP Basic or HIP Plus at this time. You can call us if you have any questions.

Family Planning and Birth Control

It is best to wait 18-24 months before getting pregnant again so your body has time to heal. The most effective birth control methods are long acting and reversible. This is called LARC (long-acting reversible contraception). Examples of LARC include intrauterine devices (IUDs), implantable contraceptive devices and others that are available with a prescription.

Benefits of LARC:

- Prevents pregnancy 99% of the time
- Easy, low-maintenance and convenient
- It can be inserted right after childbirth, even while still in the hospital
- It does not interfere with breastfeeding
- Can last up to 10 or more years

- Does not affect your ability to get pregnant again
- Easily removable
- Supports healthy birth spacing and healthy pregnancies
- Safe for women of all ages

Special Programs for Pregnant Members

CareSource MyKids and MyHealth

We offer rewards to expecting and new moms for keeping up with prenatal and postpartum visits through CareSource MyKids. Rewards can be used to buy baby food, diapers and more. See page 40 to learn more about CareSource MyKids for members 17 and younger and MyHealth for members 18 and older.

Mom and Baby Beginnings

The Mom and Baby Beginnings program is here to help you during your pregnancy. Our staff includes nurses, socials workers, counselors and breastfeeding experts. Our team will help link you to resources in your area that can help you with your pregnancy, housing, transportation, safety and food needs. They can also help answer questions you may have about pregnancy and newborn care. Our team will also work with your medical team to make sure you are healthy and safe during your pregnancy. Please call **1-833-230-2034** if you would like to learn more about how this program can help you.

Neonatal Intensive Care Program (NICU)

The NICU program helps make sure the most fragile newborns have a safe and timely discharge from the NICU to home. It has nurses and specialists that work together to offer support to mothers who have newborns in the NICU. Please call **1-800-230-2036** If you would like to learn more.

Infant Scales for NICU Babies

Some high-risk infants need their weight checked often for the first few weeks or months. Checking your baby's weight is one of the easiest ways to make sure your baby is growing as they should. It can also help show if there are potential health issues. We offer home infant scales as an enhanced benefit for some of our most at risk members.

Please call us if your baby was in the NICU, struggling to gain weight or has feeding problems. You can also talk with your care manager to learn more about getting a free infant scale.

Easy access to a scale at home gives you many benefits such as:

- Routine weight check-ins for your baby without leaving your home.
- Prevention of potential exposure to COVID-19, flu and respiratory syncytial virus (RSV).
- Early detection and checking your baby's growth and development.
- Enhanced opportunity to get feedback during a telehealth visit.
- Avoid emergency room visits that aren't needed.

Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to learn more about getting an infant scale for your baby.

CARESOURCE REENTRY PROGRAM™

Getting back on your feet after being jailed or in prison can be a challenge. It can be hard to find safe housing, food, and health care. You may also face mental health issues or struggle with substance use.

We work with the Indiana Department of Correction to help you get back to daily life if you were jailed or in prison.

We have Community Justice Liaisons (CJLs) to help support you if you need it. CJLs can help you:

- Go over your medical and mental health needs
- Find resources in your area
- Help you set future goals

Our CJLs want to make sure that you have the health care you need when released. You can also get help finding a job or going back to school by working with a Life Coach through CareSource Life Services.

Learn more about the CareSource Reentry Program by calling **317-982-6495** or emailing **IndianaRe-entry@CareSource.com**.

Expungement

Expungement means to erase a past criminal offense from a person's record. We will cover the cost of expungement up to $500 if you are eligible. You must:

- Not have *pending* charges in any state
- Pay all fines, fees, court costs and restitution (CareSource will help cover these costs with this fund)
- Wait the required time since the offense or conviction
- Be part of the CareSource Reentry Program or CareSource JobConnect through CareSource Life Services
- Get a letter of approval from the prosecutor's office

Limits apply to funds. CareSource follows all State and Federal laws.

CARESOURCE DRIVER'S LICENSE REINSTATEMENT BENEFIT

We know that good health is more than just good health care. Being able to drive can help you get to services that are key for your health and well-being. If you have lost your driver's license, we may be able to help you get it back. Start driving again with our driver's license reinstatement benefit.

Here are some ways we can help you get driving again:

- Education on how to get your driver's license reinstated
- Financial help up to $500 for auto insurance fines and/or fees linked to driver's license reinstatement (one-time support)
- Referrals to community resources for legal help

Limits apply to funds. CareSource follows all State and Federal laws.

Benefit Eligibility:

All members of legal driving age are eligible. Some members may not be eligible based on past driving record.

Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to find out more or visit our website at **CareSource.com.** You can also email us directly at **IN_DLReinstatement@CareSource.com**.

CARESOURCE LIFE SERVICES

Having a good education, community support and access to food and housing impacts your overall health and well-being. That's why CareSource Life Services is here for you. We can help with things that stand in the way of you reaching your goals. Members can receive one-to-one coaching from a CareSource Life Coach. You can be part of CareSource Life Services if you are:

- A CareSource member of legal working age or
- Parent or guardian of a CareSource member

We can link you to services and resources for:

- Transportation
- Access to food
- Budgeting and finance assistance
- Legal assistance
- Housing support
- Childcare
- Employment opportunities (CareSource JobConnect)

Connect with CareSource Life Services by:

- Phone: **1-844-607-2832**
- Email: **LifeServicesIndiana@CareSource.com**
- Online: **https://secureforms.caresource.com/en/LSRInfo/IN**

CARESOURCE JOBCONNECT

CareSource JobConnect can help you learn new skills, link you with local services and find a job. You'll be paired with a Life Coach. They can help set you up for success. Life Coaches provide one-on-one coaching for up to 24 months. CareSource JobConnect partners with employers to help you in your job search. This is all provided at no cost to you. To learn more, please fill out our online form at **secureforms.caresource.com/en/LSRInfo/IN**. You can also call us at **1-844-607-2832** or email **LifeServicesIndiana@CareSource.com.**

If you are working with the CareSource Life Services team you may have access to assistance. The member assistance fund can help you remove barriers that prevent you from working and/or meeting your basic needs. We must exhaust all existing resources in the community for your needs before you can use the fund. Your Life Coach will fill out an application for approval to use the fund. The maximum member benefit is $500 per year (Jan-Dec). Areas of support may include:

- Transportation
- Childcare assistance
- Work related expenses
- Pre-employment supports
- Housing and utility assistance
- High School Equivalent (HSE) exams
- Food access and education

*Member assistance funds are only for CareSource members who are part of CareSource Life Services. Limits apply to funds. CareSource follows all State and Federal laws.

MYRESOURCES

Sometimes you just need a little extra help. We have a search tool called MyResources that helps you find free or low-cost programs and support in your local area. You can use this tool on your own to look for help with:

- Food
- Shelter
- School
- Work
- Financial support
- And more!

We have programs across the state from small towns to large cities. Log into your **MyCareSource.com** account to use this tool. You can also call Member Services to find support near you.

TOBACCO FREE

Are you ready to quit using tobacco? We are here to help! Using tobacco in any form can harm your health. It can even cause diseases that can lead to death. We help members stop using tobacco. We also offer rewards for taking part in Quit Now Indiana. Just call **1-800-784-8669**.

Through Quit Now Indiana, you have access to:

- A free and confidential Quit Coach
- Online tools and resources
- Your own quit guide

How Does CareSource Help Members Stop Using Tobacco?

You can also use covered benefits and services to help stop using tobacco. These benefits include:

- Medicine
- Web-based education and tools
- Behavioral counseling
- Support from a Care Manager

You can earn rewards for getting help to quit tobacco.

Tobacco Cessation Activity	Reward Amount	Plan
1st call with Indiana Tobacco Quitline	$50	HIP and HHW
1st call with Indiana Tobacco Quitline for Pregnant members	$80	HIP and HHW
Completion of program	$50	HIP and HHW

**Additional rewards available for working with your health care provider to quit using tobacco. Call Member Services for more information.*

Are you pregnant and want to quit tobacco use?

Quit Now Indiana can help! Learn more at **www.quitnowindiana.com/pregnancy-and-smoking.**

Rewards for Stopping Tobacco Use

Learn about programs that can help you quit. Call Member Services at: **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

ELIGIBILITY AND ENROLLMENT

WORDS TO KNOW:
Benefit Year: January through December. Your benefit limits reset each January.
Eligibility Period: The months you have full coverage and benefits.
Enrollment Broker: A person who can help get you enrolled in a plan.

Redetermination

To stay a CareSource member, you must renew your benefits with the state. You can renew in one of these ways:

- Online. Login to your FSSA Benefits Portal at fssabenefits.in.gov to complete your renewal online.
- By Mail. Fill out the renewal forms. Please include any additional information the state has asked for.
- In Person. Visit your local Division of Family Resources (DFR). Find the office nearest to you at www.in.gov/fssa/dfr/ebt-hoosier-works-card/find-my-local-dfr-office/. Turn in your completed renewal form and any other requested information at your local DFR.

The state will send you a renewal notice when it is time to renew your coverage.

Please make sure that FSSA and CareSource have your current address and phone number. Watch your mail for reminders from CareSource. You should also watch your mail for your renewal form from FSSA. You could lose your eligibility for health care coverage and your extra benefits.

Have Questions?

Call **1-800-403-0864** or visit **fssabenefits.in.gov**.

Changing Health Care Plans

We hope you will be happy with CareSource. Please call us if you have problems or concerns about your benefits.

You have the right to change your health plan at certain times of the year. You can change your plan:

For HHW Members:

- During the first 90 days as a member
- During plan selection period from November 1 to December 15. To do this call the Indiana Medicaid Enrollment Broker:
  - Hoosier Healthwise (HHW): 1-800-889-9949
- You also have the right to change plans if you have just cause to change. Just cause means an approved reason. The list of just causes reasons is below.

Please call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you have questions about changing health care plans for an approved reason.

HHW (Just Cause)

Hoosier Healthwise members may change plans at any time for just cause. Members must file a grievance with their health plan before a determination will be made upon their just cause request. Just cause reasons include, but are not limited to:

1. Receiving poor quality of care;
2. Failure of the Contractor to provide covered services;
3. Failure of the Contractor to comply with established standards of medical care administration;
4. Significant language or cultural barriers;
5. Corrective action levied against the Contractor by the office;
6. Limited access to a primary care clinic or other health services within reasonable proximity to a member's residence;
7. A determination that another MCE's formulary is more consistent with a new member's existing health care needs;
8. Lack of access to medically necessary services covered under the Contractor's contract with the State;
9. A service is not covered by the Contractor for moral or religious objections;
10. Related services are required to be performed at the same time and not all related services are available within the Contractor's network, and the member's provider determines that receiving the services separately will subject the member to unnecessary risk;
11. Lack of access to providers experienced in dealing with the member's health care needs;
12. The member's primary healthcare provider disenrolls from the member's current MCE and reenrolls with another MCE; or
13. Other circumstances determined by the office or its designee to constitute poor quality of health care coverage

The following are causes for which Hoosier Healthwise members can be disenrolled from the Hoosier Healthwise program:

- The member was enrolled in error or because of a data entry error.
- The member loses eligibility in Hoosier Healthwise.
- The member moves out of State.
- The member is deceased.

For HIP Members:

You can change your plan before getting full benefits. You can do this within 60 days. Your health plan choice will run through the calendar year. You will pick your plan once per year. You will stay with that plan all year, January through December. This is called your Benefit Year. If you leave the program and return during the year, your plan is the same. Here is how it works.

- You can change your health plan for the next benefit year from November 1– December 15. Whatever you choose during this time will start in January. You can do this by calling 1-877-GET-HIP9 (1-877-438-4479).
- Let them know you want to pick a new plan for the next year.
- If you like CareSource, do nothing! You will be assigned to us for next year.
- Exceptions are made for members who miss the health plan selection period due to one of these reasons:
- A move from another program to HIP,
- Redetermination timing, or
- Not being fully eligible during the choice period.

HIP members must stay with their plan for 12 months, even if they have a gap in coverage.

To change your health plan, call 1-877-GET-HIP9 (1-877-438-4479). You can see a for cause list below.

HIP (For Cause)

Healthy Indiana Plan members have the right to disenroll from the plan:

1. For cause, at any time.
2. Without cause within ninety (90) days after initial enrollment or during the ninety (90) days following notification of enrollment, whichever is later.
3. Without cause at least once every twelve (12) months.
4. Without cause when a Contractor repeatedly fails to meet substantive requirements in sections 1903(m) or 1932 of the Social Security Act or 42 CFR 438 and section 1932(e)(2)(B)(ii) of the Social Security Act.
5. Without cause upon reenrollment if a temporary loss of enrollment has caused the enrollee to miss the annual disenrollment period.

In accordance with 42 CFR 438.56(d)(2)(i)-(v), members may request disenrollment if the:

- Member moves out of the service area.
- Contractor does not cover the service the enrollee seeks, because of moral or religious objections.
- Member needs related services to be performed at the same time and not all related services are available within the provider network. The member's provider must determine that receiving the services separate would subject the member to unnecessary risk,
- Contractor's provider status changes from in-network to out-of-network causes the member to have to change their residential, institutional, or employment supports provider, and, as a result, the member would experience a disruption in their residence or employment.
- Member experiences poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member's care needs.

Once you have exhausted CareSource's internal grievance and appeals process you may submit a change in health care plans request to an enrollment broker. You can submit this request verbally or in writing. The enrollment broker will be able to help with questions about the process. This help includes instructions on how to get a form for requesting a health plan change. CareSource does not terminate enrollment or approve disenrollment.

Indiana Medicaid Enrollment Broker Phone Numbers

Hoosier Healthwise (HHW): **1-800-889-9949**
Healthy Indiana Plan (HIP): **1-877-438-4479**

American Indian/Alaska Native Notice

American Indians and Alaska Natives (as defined by the Indian Health Care Improvement Act of 1976) may choose to not use managed care. American Indians and Alaska Natives can change to State fee-for-service benefits. If you want to learn more or would like to change services, you will need to talk with the enrollment broker.

All American Indian/Alaska Native (AI/AN) members can get care from Indian health care providers. This choice is offered no matter network participation status. AI/AN members may choose to have an Indian health care provider as their PMP if they are in the CareSource network, an eligible PMP and they have the space to provide the services.

We will pay for services in the same way network providers are paid when getting treatment from out-of-network health care providers. Cost share requirements, prior authorizations and benefit coverage is the same for network providers and Indian health care providers.

Other Insurance

Call us if you or other family members have another health plan. For example, if your children are covered by their other parent or if you get health care coverage through work. We will work with you and your other insurance to pay your claims. Just call us! If you or other family members are:

- Hurt at work and have a workers' compensation claim
- Involved in a personal injury or medical malpractice lawsuit
- Hurt because of a car accident
- Hurt because of another person's negligence, like a dog bite or a slip and fall accident
- To tell us if you or a family member has insurance changes
- To let us know if you or another family member become eligible for Medicare or have new health insurance

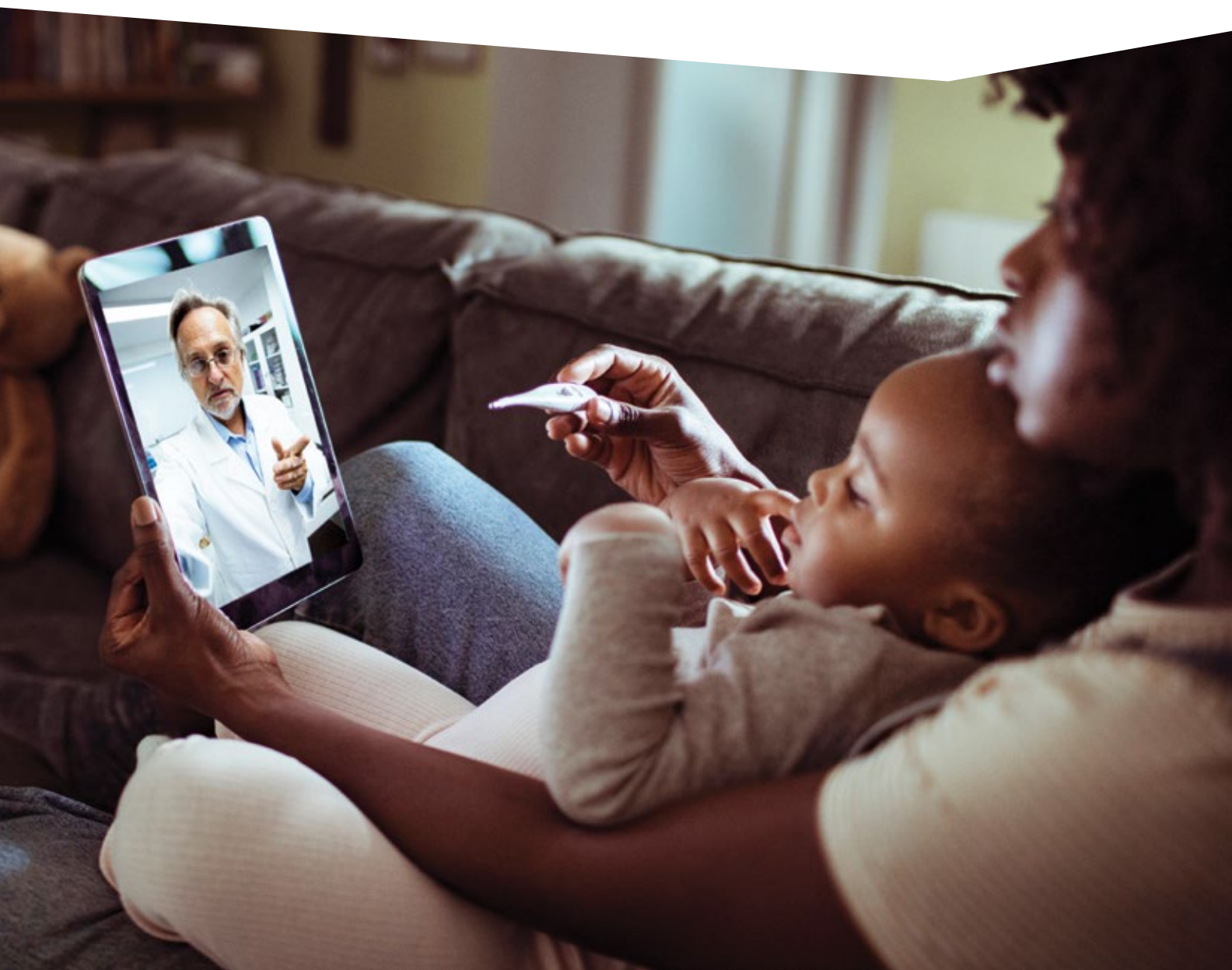
Note: A change could mean the loss of your other health insurance or could cause other changes to your insurance coverage.

Emergency or Urgent Care Outside of Our Service Area

Did you get emergency care that was not in-network? Did you need urgent care outside of the service area? You may need to send the bill to us with a claim form.

You can get a Member Claim Form at **caresource.com/in/members/tools-resources/forms/medicaid/**. You can also call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711), Monday through Friday, 8 a.m. to 8 p.m. Eastern Time.

You can also call the CareSource24 Nurse Advice Line for help at **1-844-206-5947** (TTY: 1-800-743-3333 or 711).



MEMBERSHIP RIGHTS AND RESPONSIBILITIES

Your Membership Rights

As a CareSource member, you have these rights:

- To receive information about CareSource, its services, its practitioners and health care providers and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for your dignity and privacy.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally authorized to get information on your health. This person could be reached in an emergency if you are unable to receive the information on your own.
- To request information at any time on our physician incentive plan or marketing materials.
- To be able to take part in decisions about your health care with practitioners, unless it is not in your best interest.
- To get information about any medical care treatment in a way that you can understand.
- To get care that is culturally sensitive and respectful.
- To be sure that others cannot hear or see you when 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 ask and get a copy of your medical records. And to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about yourself given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If you say no, the health care provider or CareSource must talk to you about what could happen, and a note must be placed in your medical record about the treatment refusal.
- To be able to file an appeal, a grievance (complaint) or State Fair Hearing.
- To voice complaints or appeals about the organization or the care it provides.
- To be able to get all CareSource written member information from CareSource:
  - At no cost to the member in the prevalent non-English languages of members in CareSource's service area.
  - For members with special needs with reading the information for any reason.
- To be able to get help free of charge from CareSource and its health care providers if the member does not speak English or needs help understanding the information.
- To be able to get help with sign language if the member is 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 an advance directive (a living will).
- To file a complaint with the Indiana Office of Medicaid Policy and Planning (OMPP) about not following the member's advance directive.
- To be free to carry out your rights and know that CareSource, CareSource providers, or the Indiana Office of Medicaid Policy and Planning (OMPP) will not hold this against you.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply, to choose the health care provider that gives you care whenever possible and appropriate.
- If you are a female member, you have the right to see a CareSource provider specializing in women's health.
- To be able to get a second opinion from a qualified provider on CareSource's panel, and if a qualified provider is not able to see the member, CareSource must set up a visit with a provider not on its panel.
- To go out of network for care provided out of cost if CareSource is unable to provide a covered service within 60 miles of your home in our network.
- To get information about CareSource's structure and operation.
- To make recommendations regarding CareSource's member rights and responsibility policy.

Member Responsibilities

As a CareSource member you have these responsibilities:

- Use only approved health care providers.
- Keep scheduled health care provider appointments. Be on time and call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your ID card and present it when receiving services.
- Never let anyone else use your ID card.
- Alert CareSource of any suspected fraud or abuse per the instructions in this handbook.
- Notify your county caseworker and CareSource of a change in phone number or address.
- Contact your PMP after going to an urgent care center or after getting physical or mental health and addiction services care outside of CareSource's covered counties or service area.
- Let CareSource and the county caseworker know if you have other health insurance coverage.
- Provide the information that CareSource and your health care providers need, to the extent possible, in order to provide care.
- Understand as much as possible about your health issues and take part in reaching goals that you and your health care provider agree upon.

UTILIZATION MANAGEMENT

Utilization Management (UM) means CareSource reviews a request for certain health care services. The review can happen before, during or after service. We will review the request for:

- Medical necessity
- Efficiency (Getting the concern addressed quickly)
- Appropriateness of health care services
- Treatment that our members get

Call Member Services at the number at the bottom of the page if you have questions about how we review your care. You can ask to talk with someone on the UM team. When calling, please keep in mind:

- UM is open for calls Monday – Friday from 8 a.m. to 5 p.m. Eastern Time. You may leave a message about UM issues after normal hours.
- Visit **CareSource.com** to reach out to UM during and after normal hours.
- Use the Tell Us form at **secureforms.CareSource.com/MemberInquiry**.
- A UM staff member who calls will say their name, title, and company (CareSource).

You can call us about:

- UM for prior authorization (pre-approval) requests
- Any other UM issues and concerns

We can also help members who speak other languages. Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

How We Review Requests:

- We use up to date clinical information and generally accepted guidelines to guide clinical decision making.
- We do not reward health partners or our own staff for turning down coverage or services.
- We do not offer financial rewards to our staff to make decisions that result in under-use of services.
- Clinical review staff are health care professionals. They have clinical expertise in treating the conditions for requests they are reviewing.

Review of New Technology

We rely on research and advances in science to provide members high quality health care. We have a New Technology Committee. It is made up of physicians across CareSource. They evaluate medical advances to decide if they are high quality and safe.

We will review any requests for new technology or services that are not currently covered by your plan. This includes newly developed:

- Health care services
- Medical devices
- Therapies
- Treatment options

Coverage is based on one or more of the following:

- State Medicaid rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

We do not cover any therapy that is considered experimental.

INQUIRY, GRIEVANCE AND APPEALS

WORDS TO KNOW:

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

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

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

Expedite – To hurry, speed up or make something go faster.

We hope you are happy with CareSource and the care you get. Let us know if you are unhappy or do not agree with a decision made by CareSource or our providers.

Please call Member Services if you need help filing a grievance or an appeal. We can help you fill out forms and take other needed steps. We can also help by giving you toll free numbers with TTY and interpreter services.

Call Member Services if you have a complaint or suggestion for changes in policies and services. We will resolve inquiries by the close of the next business day after we hear from you. The inquiry will become a grievance if we don't get back to you within this time frame.

We Can Help

Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

What is a grievance? If you are unhappy with a provider or with us, you can file a grievance at any time. It can be about anything except CareSource benefit decisions. Grievances do not go to the state for a hearing.

Examples of things you might file a grievance for:

- CareSource staff was unkind.
- Quality of care.
- A provider was rude.
- Failure to respect your and/or employee rights.

How and When to File a Grievance

You can file grievances verbally, online or in writing at any time.

You or your authorized representative can file a grievance with CareSource. An authorized representative is someone who can speak on your behalf. Here are the ways you can file a grievance:

- **Call** Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).
- **Send a letter to:**

CareSource
Attn: Member Grievance
P.O. Box 1947
Dayton, OH 45401

- Online: **MyCareSource.com** (Member Portal)
- Email: **INMCDGRIEV@caresource.com**

Note: A health care provider may not file a grievance for you unless they are acting as your authorized representative. They must have your written permission.

Grievance Process

We will send you a letter within three business days to let you know that we got your grievance.

- CareSource will look into your grievance.
- CareSource will review your grievance quickly, within thirty (30) calendar days of your filing the grievance.
- Is your grievance because you are in a health crisis? You can ask for an expedited (faster) review. This means that we will let you know within 48 hours.
- CareSource will send you a letter to tell you the result of the grievance. If you had an expedited grievance, we will try to notify you orally and in writing.

What is an appeal? An appeal is when you tell us if you do not agree with a decision we made to deny a service or benefit claim. You can also appeal when we only approve part of a claim. You have 60 days for the date of the initial denial notice to file an appeal. You have the right to a hearing at the state level with an appeal.

Appeals Process

You may ask for an appeal of a decision we make to deny a service or benefit claim. We will send a letter when we deny a service or benefit claim. Here are some examples of things you might file an appeal for:

- Denial of service
- Denial, termination or reduction on a service that was previously approved
- Not giving a timely service
- CareSource not acting in the right time frames
- Medically frail determination
- Denying part or all of the payment for a service
- Not giving services in a timely manner
- Denying your right to argue a charge

If you file an appeal, you must ask for an appeal within 60 calendar days from the notice date. You or your authorized representative can file an appeal with CareSource. You also have a right to an expedited appeal. Call **1-844-607-2829** (TTY: 1-800-743-3333 or 711) or mail a letter to:

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

Email: INMCDGRIEV@caresource.com
Online: MyCareSource.com (Member Portal)

You or someone acting for you, including a provider, may file an appeal verbally or in writing. They need your written consent to act for you. We'll send you a letter within 3 business days letting you know we got your appeal.

The people making appeal decisions are not part of prior reviews or decision making. They are health care professionals. They are supervised by our medical director. They have clinical expertise in your health condition.

Some other things to know about appeals:

- You will be able to share proof in person or in writing.
- Anyone acting on your behalf and with your written consent may file an appeal.
- You can also review your case file and health records.
- You can review any other appeal process papers free of charge.
- CareSource will tell you when we need this information for an expedited review.

Appeal Decision

If you are at an inpatient facility, CareSource will tell you and your health care provider/facility the appeal decision. This will be done by written notice on the day of the decision. The decision notice will be sent to you. It will also be sent to others acting for you with your written consent.

CareSource will reply to an appeal in writing as fast as your health condition requires. We will reply no later than 30 calendar days from when we got your standard appeal. We will reply within 48 hours for an expedited appeal. The member or health care provider can ask for an expedited appeal. Appeals will be expedited when CareSource decides that going by the standard timeframe could seriously harm your life, health or ability to attain, maintain or regain maximum function. If it does not meet expedited review criteria, we will tell you. We will send you a letter in two calendar days saying the matter does not meet expedited criteria. It will be handled under the standard appeal process.

You may ask for a State Fair Hearing if you do not agree with us.

Before you can ask for an **external review** and/or a **State Fair Hearing**, an internal appeal process is done. If CareSource does not follow the notice and timing rules in this handbook, then you may ask for a State Fair Hearing before our internal appeal process is finished.

Extending the Appeal Timeframe

You or someone acting for you with your written consent can ask that CareSource extend the time frame to resolve a standard or expedited appeal up to 14 calendar days. We may also ask for up to 14 more calendar days to resolve a standard or expedited appeal. This will happen if we show that there is a need for more information and how the delay is in your best interest. We will immediately give you written notice of the reason for the extension and the date that a decision must be made.

Independent External Review

If you do not agree with our appeal decision, then you can ask for an Independent Review. You or your authorized representative must ask for an Independent, external review within 120 calendar days of the date on our appeal decision. This is at no cost to you. The Independent Review Organization (IRO) will give you an answer within 72 hours for expedited, or 15 business days for a standard.

- **Call: 1-844-607-2829** (TTY: 1-800-743-3333 or 711)
- **Online: MyCareSource.com** (Member Portal)
- **Email:** INMCDGRIEV@caresource.com
- **Mail:** CareSource, Attn: Member Appeals, P.O. Box 1947, Dayton, OH 45401-1947

Be sure to give your name, your member ID number and a phone number where we can reach you. We will also need the reason for your appeal, and any information you feel is important to your appeal request. This can be comments, documents, medical records or provider letters.

Indiana State Fair Hearing

If you do not agree with our appeal decision, you can ask for a State Fair Hearing. You or your authorized representative must ask for a State Fair Hearing. This needs to be done within 120 calendar days of the date on our appeal decision. A provider may not ask for a State Fair Hearing for you. They can only do this if they are acting as your authorized representative and/or has your written consent.

Please send your request by:

Mail: Office of Administrative Law Proceedings
100 N. Senate Avenue, Suite N802
Indianapolis, IN 46204
OR
Phone: 1-317-232-4405

What to Expect at a State Fair Hearing

The Office of Administrative Law Proceedings will tell you the time, place and date of your hearing. Here's how a State Fair Hearing works:

- The people who will go to the hearing include you and others acting for you with your written consent. There will also be CareSource agents and a fair Administrative Law Judge.
- In the hearing, you can speak for yourself or let someone speak for you. You may also have a lawyer speak for you. You will have time to review your files and other important information. CareSource will have records and witnesses for you that are important to your hearing.
- CareSource will explain its decision. You will explain why you don't agree with the decision. The Administrative Law Judge will make the final decision. CareSource will obey the decision.

Continuation Of Benefits During an Appeal Or State Fair Hearing

CareSource will continue your benefits if:

- You or your authorized representative files an appeal timely*
- The appeal involves ending, delaying, or reducing a previously authorized course of treatment
- The services were ordered by an authorized provider
- The time covered by the original authorization has not ended
- You ask for an extension of the benefits

Please be aware that you may have to pay the cost of services used during the appeal if the result is an adverse decision.

*Timely means filing within 10 calendar days of CareSource mailing the notice of our appeal decision or the intended effective date of CareSource's adverse benefit determination. If, at your request, CareSource continues your benefits while the appeal or State Fair Hearing is pending, the benefits will be continued until:

- You withdraw the appeal or request for the State Fair Hearing.
- You do not ask for a State Fair Hearing and continuation of benefits within 10 calendar days after CareSource sends its appeal decision.
- An Administrative Law Judge makes a decision that is not in your favor or:
  - The time or service limits of a pre-approved service has been met.
- If the final decision of an appeal or State Fair Hearing is not in your favor, then we may ask you to pay back the cost of care you got while the appeal or hearing was pending. If CareSource or the Administrative Law Judge changes a decision that is in your favor, then we will get you those services fast and as quickly as your health requires.
- If CareSource or the Administrative Law Judge changes a decision to deny services, but you already got the services, we will pay for those services.

If you need to file a grievance or appeal, fill out the form on the next page. You may send this form by:

Mail: CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

Email: INMCDGRIEV@caresource.com

Online: **MyCareSource.com** (Member Portal)

Calling Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711)

Thank you for being a CareSource member.

MEMBER GRIEVANCE AND APPEALS FORM

Member Name
Member ID#
Member Address
Phone: (Best phone number to reach you at if you have questions or need more information about to your issue:)
Please write a description of the grievance or appeal. Give us as much detail as possible. Include the provider's information if your issue concerns a provider. You may attach additional pages, if needed.

(Member Signature)	**(Date)**

If you have questions, please call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

OFFICE USE ONLY

Received By:

Grievance:

Appeal:

Hearing:

PRIVACY PRACTICES

This notice describes how health information about you may be used and given out. It also tells how you can get this information. Please review it carefully. The terms of this notice apply to CareSource Hoosier Healthwise and Healthy Indiana plans. 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 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 will not share your health information, including Sensitive Health Information (SHI), unless you tell us to do so. 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. If you give us permission to share, this information would be shared to handle your care and treatment or to help with benefits. This information would be shared with your past, current and future treating providers. It would also be 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 want your health information (including SHI) shared. If you do not want 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: https://www.hhs.gov/hipaa/for-individuals/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.

To learn more go to: 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 22, 2018. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice. The new one would apply to all health information we keep. If this happens, the new notice will be available upon request. It will also be posted on our web site. You can ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

The CareSource Privacy Officer can be reached by:

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

Email: **HIPAAPrivacyOfficer@caresource.com**

Phone: **1-844-607-2829**, ext. 12023 (TTY: 1-800-743-3333 or 711)

ADVANCE DIRECTIVE

An Advance Directive tells people in writing what your health care wishes are. It tells your health care team what you want or do not want. You may name a person who can or who cannot make health care choices for you in an Advance Directive. A person must be 18 years or older (or an emancipated minor) to write one.

Advance Directives Under Indiana Law

The State of Indiana has created a legal document called an Advance Directive for Health Care. It is a mix of a living will and a Health Care Power of Attorney. You can find a copy of the form at Indiana's Advance Directives Resource Center at **www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/**. An Advance Directive for Health Care must be made in writing.

Using Advance Directives to State Your Wishes About Your Medical Care

Many people worry about what would happen if they become too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to live longer.

Members Have A Choice

More people are making their medical care and mental health care wishes known in writing while they are healthy and able to choose. Health care providers must let you know about your right to state your wishes about medical care. The provider also must ask if your wishes are in writing and add your Advance Directive to your medical record.

- You have the right to say yes or no to a medical or surgical treatment. You also have the right to write an Advance Directive. You do not have to make one, but it is a good idea.
- You will need to answer some tough questions when making an Advance Directive. If you choose to have an Advance Directive, you need to make sure your wishes are written out before you are too sick to make choices. You should think about these things when writing an Advance Directive:
  - It's a choice to write an Advance Directive.
  - The law states that people can make choices about health care. They can choose to say yes or no to any medical treatment.
  - Having an Advance Directive does not mean the person wants to die.
  - An Advance Directive can only be filled out by people of sound mind.
  - A person must be at least 18 years of age (or an emancipated minor) to write an Advance Directive.
  - Two people should see an Advance Directive signed for it to be valid.
  - Having an Advance Directive will not affect other insurance.
  - Advance Directives should be kept in a safe place. A copy should be given to a family member, health care agent and PMP.
  - You can change your Advance Directive any time.

There are Three Parts of an Advance Directive for Health Care

Part 1: Lets you choose someone to make health care choices for you when you cannot or do not want to. This person becomes your health care agent. This agent does not have to use the powers given to them for health care.

Note: You should carefully think about who you pick as a health care agent.

Part 2: Lets you make your wishes known about things such as getting or stopping life support, food or liquids. Part 2 will only go into effect if you cannot tell others the care you want.

Part 3: Lets you choose a guardian if a court says that you need one. You do not need to complete all parts of an Advance Directive. You can just fill out the parts you want. You can change your Advance Directive at any time.

What To Do If Your Advance Directive for Health Care Is Not Followed

You can make a complaint if your Advance Directive is not being followed.

Write or call:

Mail: Family and Social Services Administration (FSSA)
402 West Washington Street
Indianapolis, IN 46204-2243

Phone: 1-800-457-4584

Contacts for an Advance Directive for Health Care

You can find more information about Advance Directives by:

- Talking with your PMP
- Going online: **www.in.gov/medicaid/members/**
- Calling the Indiana Family and Social Services Administration (FSSA) at 1-800-457-4584
- Calling CareSource Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711)
- Visit the Indiana Department of Health's Advance Directive Resource center at **www.in.gov/health/cshcr/indiana-health-care-quality-resource-center/advance-directives-resource-center/**

Type of Advance Directives Recognized in Indiana

- Health Care Representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Organ and tissue donation
- Out of Hospital Do Not Resuscitate Declaration and Order Physician Orders for Scope of Treatment (POST)
- Power of Attorney
- Psychiatric advance directives

For more information on Advance Directives and to find forms available to you, please visit Indiana Health Care Quality Resource Center at www.in.gov/isdh/25880.htm.

QUALITY MANAGEMENT AND IMPROVEMENT PROGRAM

CareSource has a Quality Management and Improvement Program. This section talks about this program and why we have it. Call us at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you need help understanding this information.

Program Purpose

We have the Quality Management and Improvement Program to make sure that you get the care you need.

Health Care

- Helps you get the right care
- Helps you get care at the right time
- Helps you get care from the right health care providers

Quality

- Makes sure you get the best care, services and outcomes
- Makes sure you get high quality health care on a regular basis

Our Mission, Our Heartbeat

We aim to make a lasting change in our members' health and well-being through health programs and life services. We seek to:

- Make members' health our top priority
- Get the best possible results
- Lower health care costs and increase value

Program Overview

CareSource works every day to be a top performing health plan. The Indiana Chief Medical Officer oversees the CareSource Quality Management and Improvement Program. The Quality Department and other departments within CareSource carry out the program. We monitor quality and make improvements by:

- Meeting the requirements of the Centers for Medicare and Medicaid Services (CMS) and the Indiana Family and Social Services Office of Medicaid Policy and Planning.
- Make sure all of our health care providers are using safe clinical practices

We keep a close watch on the quality of care and services we offer. This is done by using data and reports to monitor how well our providers are taking care of members. We look at data to decide on what types of programs we need to improve your care and health results. Our goals include:

- National Committee for Quality Assurance (NCQA accreditation). NCQA's goal is improve the quality of health care in the United States.
- Obtaining an NCQA Health Plan rating of 5 (highest rating)
- Complying with NCQA Accreditation Standards for health care and services

We use HEDIS® (Healthcare Effectiveness Data and Information Set) to help measure the quality of care provided to members. HEDIS® is used by health plans in the United States to determine if members are getting important health care services and how well we do at providing the services. HEDIS® measures are based on national scientific guidelines that are known to help you take care of your health condition and improve health. This includes:

- Regular check-ups for adults and children
- Preventive screenings, for example breast cancer screening
- Follow-up on long-term health conditions, for example: asthma, depression, diabetes, high blood pressure
- Mental health and addiction
- Vaccines
- Lead testing (children)
- Attention Deficit Hyperactivity Disorder (ADHD) prescription drug safety

We also use the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey. This member survey provides us with your comments on the quality of care you receive. The CAHPS® survey is directed by the United States Department of Health and Human Services, Agency for Healthcare Research and Quality. CAHPS® asks about:

- Customer Service
- How quickly you were able to get the care you needed
- Rating your personal doctor and specialists, including how well they communicate with you
- Rating other health care services you received
- Overall rating of CareSource as your health plan

Our goal for HEDIS® measures and the CAHPS® survey is to get the highest possible scores. We work with all our providers to make sure the diverse needs of our members are met.

We make changes based on the member's needs. Changes are based on the comments we get from members, providers, and other business. Each year we update information about the program. You can find it on our website, **CareSource.com**.

PREVENTATIVE GUIDELINES AND CLINICAL PRACTICE GUIDELINES

We use nationally accepted standards and guidelines to help inform and guide the clinical care provided to members. These are reviewed and approved by the Enterprise Provider Advisory Committee at least every two years.

Guideline topics are based on the needs of our members. They help us measure how we are doing in taking care of your health care needs. You can ask for copies of guidelines and health resources. You can do so by calling us. Some guidelines include:

- Preventive health, for example, vaccines, breast cancer screenings
- Mental health and addiction services, for example depression, ADHD, Substance Abuse Disorder
- Population health for example, maintaining a healthy weight and help to stop smoking
- Long-term health conditions, such as asthma, diabetes, high blood pressure, lung disease

Your Health Is Important

Here are some ways that you can take care of your health:

- Develop a relationship with your health care provider.
- Make sure you and your family have regular checkups.
- Make sure if you have a long-term condition (such as asthma or diabetes) that you see your health care provider regularly.
- Follow the treatment that your health care provider has given you.
- Make sure that you take the prescription drugs that your health care provider has asked you to take.
- Remember our CareSource24 Nurse Advice Line is available to help you. You can call the number on your member ID card, 24/7/365.
- Reach out to our Care Management team. They can help you manage health conditions and give you support.

Please call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) if you would like to learn more about Quality Improvement.

FRAUD, WASTE AND ABUSE

Medicaid can be misused, ending in fraud, waste or abuse.

WORDS TO KNOW

- **Fraud** means the purposeful misuse or for gain of benefits.
- **Waste** means overusing benefits when they are not needed.
- **Abuse** is action that causes unneeded costs to Indiana's Medicaid Program. Abuse can be caused by a provider or a member. Provider abuse could be caused by actions that do not meet good fiscal, business, or medical sense. They also can be paying for care that is not needed.

Watching for fraud, waste and abuse is vital. It is handled by CareSource's Program Integrity department. Help us by letting us know if there are issues. Fraud, waste or abuse can be done by providers, drugstores or members. We check and act on any provider, drugstore, or member fraud, waste and abuse.

Here are ways provider fraud, waste and abuse may happen. This can include doctors or other health care providers who:

- Prescribe drugs, equipment or services that are not medically necessary.
- Fail to provide patients with medically necessary services due to lower reimbursement rates.
- Bill for tests or services not provided.
- Use wrong medical coding on purpose to get more money.
- Schedule more frequent return visits than are medically necessary.

Examples of pharmacy fraud, waste and abuse include:

- Not giving you medicines as written.
- Sending claims for a costly name brand drug instead of a generic drug.
- Giving a member less medication than written and not letting them know where to get more.

Examples of member fraud, waste and abuse include:

- Inappropriately using services such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy.
- Changing or forging prescriptions.

- Using pain medications you do not need.
- Sharing your ID card with another person.
- Not telling us that you have other health insurance coverage.
- Getting equipment and/or supplies you don't need.
- Getting services or picking up medicines with another person's ID (identity theft).
- Giving wrong symptoms and other to providers to get treatment or drugs.
- Too many ER visits for problems that are not emergencies.
- Lying to get Medicaid benefits.

If you are proven to have abused or misused your covered benefits you may:

- Have to pay back any money that we paid for services which were determined to be a misuse of benefit
- Be prosecuted for a crime and go to jail or
- Lose your Medicaid benefits

IF YOU SUSPECT FRAUD WASTE OR ABUSE

If you think someone is committing fraud, waste or abuse, you must let us know.

You can tell us in one of these ways:

- Call: **1-844-415-1272** (TTY: or 711)
- Web: Go to **CareSource.com** and fill out the form
- Mail: CareSource, Attn: Program Integrity Department, P.O. Box 1940, Dayton, OH 45401-1940
- Email: **fraud@caresource.com**
- Fax: 1-800-418-0248

Please share as much as you can when you alert us about fraud, waste or abuse. Give us names and phone numbers if you know them. You do not have to give your name. We will not be able to call you back for more information if you choose not to give us your name. Your report will not be shared unless required by law.

**Most email is not protected from third parties. This means people may get your email without you knowing or saying it is okay. Please do not use email to tell us things that you think should be kept private. Don't send us your member ID number, social security number or health information through email. Please use the form or the phone number above.*

THANK YOU FOR HELPING US KEEP FRAUD, WASTE AND ABUSE OUT OF HEALTH CARE!

CONFIDENTIAL FRAUD, WASTE, AND ABUSE REPORTING FORM

Please use this form to tell us about any fraud, waste and abuse concerns you may have. This information will be confidential. Tell us as much as you can.

I think that the following person, who can be reached at the address and phone number listed below, may be doing acts of fraud, waste or abuse.

Name **Phone(s)**

Address

This person is a/an: (please check the appropriate box)

☐ Employee ☐ Member ☐ Provider ☐ Other*

Tell us your concern? Please attach extra pages, if needed.

*Please explain the relationship between the person you are reporting and CareSource or yourself.

You do not need to tell us your name. If you are willing, please give us this information so that we may reach you if we need more info.

Your Name **Your Phone(s)**

Your Address

If you have documents that we should see, please attach them or tell us where to find them.
If you do not want to give your name, send this form (and any other documents) by mail to:

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

You may also send this form by:

Fax: 1-800-418-0248
E-mail: fraud@caresource.com
(copy the form information and attachments into the email or attach them as documents).

If you have any questions, call us on the Fraud Hotline at **1-844-415-1272** (TTY: 711) and choose the *Report Fraud* menu option.

WORD MEANINGS

Advance Directives or Living Will – A written record of a person's wishes about medical treatments. This often is called a living will. This makes sure wishes are done if a person cannot tell a provider.

Annual Physical – Visits to a Primary Medical Provider (PMP) each year to check your health. It is known under many names. Some of them are general health check, preventive health exam and checkup.

Appeal – A written or verbal ask for a decision to be reversed.

Benefits – Health care that is covered by CareSource.

EPSDT – Early and Periodic Screening, Diagnostic and Treatment.

Continuity of Care – A plan where you and your care teamwork toward a health goal. This is led by your provider.

Grievance – A complaint about CareSource or its providers.

In-Network – When a doctor, hospital or other provider accepts your health insurance plan that means they are in network. We also call them participating providers.

Managed Care Entity (MCE) – This is the company that will run your health plan. CareSource is your Managed Care Entity.

Medically Frail – Members with complex physical or mental health and addiction conditions may be able to get the State Plan benefits. This is a better fit for their health care needs. A HIP member could be medically frail if they have one or more of the following:

- Disabling mental disorder.
- A chronic substance abuse disorder (SUD).
- Serious and complex medical conditions.
- Physical, intellectual or developmental disability that greatly lowers the person's day-to-day activities.
- A disability based on Social Security Administration criteria.

Medical Necessity – Services/supplies that are needed for the finding or treatment of a condition. They also meet approved standards of medical practice.

Medication – A substance used for medical treatment, especially a medicine or drug.

Member – An eligible Medicaid recipient who joined CareSource. They get health care services from our providers.

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.

Non-Participating Provider – A licensed health care professional who has not signed a contract to give services. This could be a doctor, hospital or other provider. Please see Services Outside of Network in the Prior Authorization section of this handbook.

Opioid Treatment Programs –These programs offer medication, medical and rehabilitative services to people with opioid use disorder. They have doctors, nurses and counselors who work with members on their journey to recovery.

Out-of-Network – When a doctor, hospital or other provider does not accept your health insurance plan that means they are out of network.

Participating Provider – A licensed health care professional who has signed a contract agreeing to give services. This could be a doctor, hospital or other provider. They are listed in our Provider Directory.

Primary Medical Provider (PMP) – A health care provider you have chosen in network. Your PMP works with you to meet your health goals. This can be giving you checkups and shots. It can also be treating you for most of your health care needs. Or sending you to specialists, if needed.

Prescription – A provider's order for a pharmacy to fill and give medicine to their patient.

Prior Authorization – Sometimes health care providers let CareSource know about the care they think you should get. This is done before you get the care. This makes sure it is the best care for you. It also makes sure that it will be covered. Prior authorizations are needed for some services that are not routine. This can be home health care or some scheduled surgeries.

Provider Directory – A list of health care providers and others you can go to as a member.

Provider Panel – A full listing of all providers actively working with CareSource.

Referral – A request from a provider for you to get certain services, like physical therapy, or to see a specialist for care.

Rehabilitative Services – Health care services or supplies that 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. They may involve physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in inpatient and/or outpatient settings.

Service Area – The Indiana area where CareSource is a managed care entity option for Medicaid members.

Specialist – A health care provider who focuses on a specific kind of health care (like a surgeon or a heart doctor.)

Substance Use Disorder (SUD) – A disease that impacts a person's brain and behavior. People with SUD cannot control their use of a legal or illegal drug or medication.

SUD Residential Services – Inpatient treatment for substance use disorders.

Withdrawal Management – Also called detoxification or detox. This is the phase in which your body physically withdraws from drugs.

ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
CAD	Coronary Artery Disease
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CHF	Congestive Heart Failure
CHIP	Children's Health Insurance Program
CJL	Community Justice Liaisons
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
DFR	Division of Family Resources
EPSDT	Early and Periodic Screening, Diagnostic and Testing
ER	Emergency Room
FDA	Food and Drug Administration
FPL	Federal Poverty Level
FSSA	Family and Social Services Administration
HEDIS	Healthcare Effectiveness Data and Information Set
HHW	Hoosier Healthwise
HIE	Health Information Exchanges
HIP	Healthy Indiana Plan
HNS	Health Needs Screening
HPV	Human Papillomavirus
IHCP	Indiana Health Coverage Programs
IOP	Intensive Outpatient Program
IRO	Independent Review Organization
MCE	Managed Care Entity
MTM	Medication Therapy Management
NCQA	National Committee for Quality Assurance
NEMT	Non-emergency Transportation
OMPP	Office of Medicaid Policy and Planning
OTC	Over-the-counter
PA	Prior Authorization
PDL	Preferred Drug List
PDP	Primary Dental Provider
PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility (Account)
RCP	Right Choices Program
SHI	Sensitive Health Information
SUD	Substance Use Disorder
TMJ	Temporomandibular Joint Dysfunction
UM	Utilization Management
WIC	Women, Infants and Children

ENGLISH - Language assistance services, free of charge, are available to you. Call: **1-844-607-2829** (TTY: 1-800-743-3333 or 711).

SPANISH - Servicios gratuitos de asistencia lingüística, sin cargo, disponibles para usted. Llame al: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

NEPALI - तपाईंका निम्ति निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन् । फोन गर्नुहोस्: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

KOREAN - 언어 지원 서비스가 무료로 제공됩니다. 전화: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

FRENCH - Services d'aide linguistique offerts sans frais. Composez le 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

GERMAN - Es stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Anrufen unter: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

SIMPLIFIED CHINESE - 可为您提供免费的语言协助服务。请致电：1-844-607-2829 (TTY: 1-800-743-3333 or 711).

TELUGU - భాషా సాయం సర్వీసులు, మీకు ఉచితంగా లభ్యమవుతాయి. కాల్ చేయండి: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

BURMESE - ဘာသာစကားဆိုင်ရာအကူအညီဝန်ဆောင်မှုများအား သင့်အတွက် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ရန်: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

ARABIC - تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم: 1-844-607-2829 (هاتف نصيّ: 1-800-743-3333 أو 711).

URDU - زبان کی معاونتی ترجمانی خدمات، آپ کے لیے بالکل مفت یا فری آف چارج دستیاب ہیں۔ کال کریں: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

PENNSYLVANIA DUTCH - Mir kenne dich Hilf griege mit Deitsch, unni as es dich ennich eppes koschte zellt. Ruf 1-844-607-2829 (TTY: 1-800-743-3333 or 711) uff.

RUSSIAN - Вам доступны бесплатно услуги языкового сопровождения. Позвоните по номеру: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

TAGALOG - May mga serbisyong tulong sa wika, na walang bayad, na magagamit mo. Tumawag sa: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

VIETNAMESE - Dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

GUJARATI - ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-607-2829 (TTY: 1-800-743-3333 or 711) પર કૉલ કરો.

PORTUGUESE - Serviços linguísticos gratuitos disponíveis para você. Ligue para: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

MARSHALLESE - Jerbal in jibañ ikijen kajin, ejelok onean, ej bellok ñan eok. Kurlok: 1-844-607-2829 (TTY: 1-800-743-3333 or 711).

NOTICE OF NON-DISCRIMINATION

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of age, gender, gender identity, color, race, disability, national origin, ethnicity, marital status, sexual preference, sexual orientation, religious affiliation, health status, or public assistance status.

CareSource offers free aids and services to people with disabilities or those whose primary language is not English. We can get sign language interpreters or interpreters in other languages so they can communicate effectively with us or their providers. Printed materials are also available in large print, braille, or audio at no charge. Please call Member Services at the number on your CareSource ID card if you need any of these services.
If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

Mail: CareSource, Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
Email: CivilRightsCoordinator@CareSource.com>
Phone: 1-844-539-1732

Fax: 1-844-417-6254

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

Mail:U.S. Dept. of Health and Human Services
200 Independence Ave, SW Room 509F
HHH Building Washington, D.C. 20201
Phone: 1-800-368-1019 (TTY: 1-800-537-7697)
Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are found at:
www.hhs.gov/ocr/office/file/index.html.

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