Healthy Indiana Plan (HIP)
Hoosier Healthwise (HHW)

2024 Member Handbook

CareSource®


CareSource®
Health Care with Heart

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 things easier to start your health journey with us. We believe you deserve more than high quality health care. You deserve health care with heart®.

Please review this handbook. Keep it handy so you can look at it later. You can use this handbook to:

- See tools available to you like:
  - **CareSource.com**
  - **MyCareSource.com**
  - The CareSource Mobile app
- Learn how and where to get care
- See your covered benefits, services and rewards
- Find pharmacy and medicine information
- Learn about CareSource Life Services® and CareSource JobConnect™
- Understand your member rights and responsibilities and how we keep your information private

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

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:

- New Year's Day—January 1, 2024
- Martin Luther King, Jr. Day—January 15, 2024
- Memorial Day—May 27, 2024
- Independence Day—July 4, 2024
- Labor Day—September 2, 2024
- Thanksgiving—November 28 and 29, 2024
- Christmas Eve—December 24, 2024
- Christmas Day—December 25, 2024

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:

- Personal Wellness and Responsibility (POWER) statements
- 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 three 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 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 Substance Use Disorder Hotline: **1-833-OPIOIDS (674-6437)**

Table of Contents

GETTING STARTED

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

Review Your CareSource ID Card(s)

Every CareSource member will get an 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:

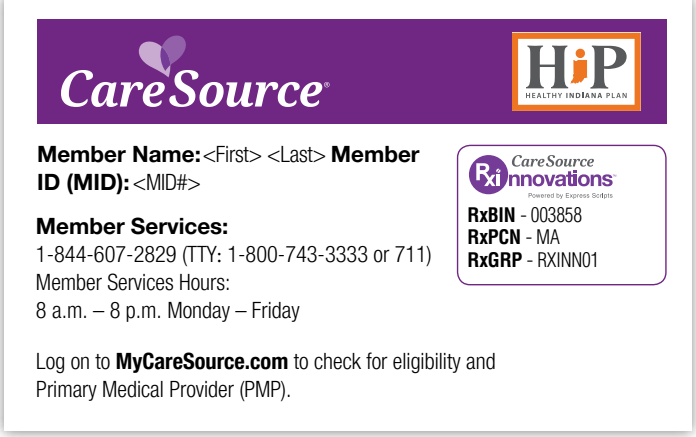
- Did not receive an ID card(s)
- Lost your ID card(s)
- Need a new ID card(s)

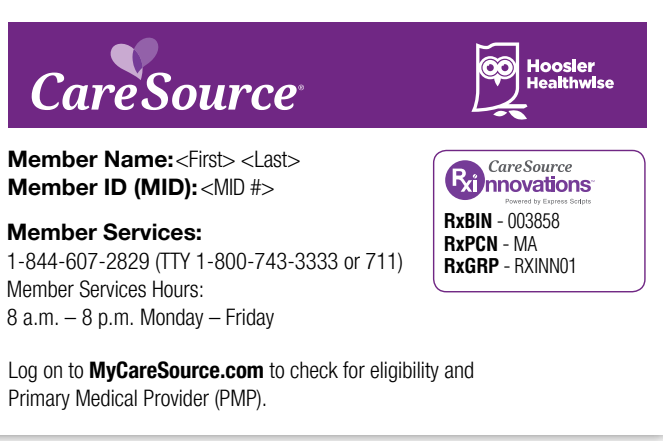
You can also sign into your My CareSource® account to order an ID card or use the mobile app to view your digital member ID card. You can learn more about My CareSource and the CareSource mobile app below.

Always keep your ID card with you.

You will need your ID card when you get health care, prescription drugs or special services. You 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.





Health Care Providers and Your Care Plan

Your benefits include health care services from providers in the CareSource network. Providers are doctors, nurses, hospitals, clinics and others. A provider who accepts your health insurance is an in-network provider. 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 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. You may not be able to get care and/or the claim may not be paid. 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.

You do not need to call if you have an in-network provider. You can find a list of providers in the CareSource network in your **MyCareSource.com** account, on the mobile app or at **findadoctor.CareSource.com**.

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.

1. Click *Search Prescriptions*
2. Enter the names of your drugs into the search tool
3. This will tell you more about how medicine and medical supplies are managed, like if your drug needs prior approval.

Your prescription might need prior approval. This means it will need to be approved before you fill it. Visit **CareSource.com/Indiana** or call Member Services to find out if your drugs need to be approved.

Ask your health care provider to get approval from CareSource if your drug needs to be approved. The drug will not be covered unless you do.

Create 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:

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

Get the CareSource Mobile App

This 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! The app is free. Get the CareSource mobile app through the App Store® for iPhone® or Google Play® for Android®.

Fill out your Health Needs Screening (HNS) and get a $30 Walmart® gift card

CareSource wants 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

The HNS can be completed 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 pre-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.

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

These 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.

It is easy to choose a different PMP if you want one. Just log into My CareSource®, 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). Please let us know if you have a new PMP. Call their office to make an appointment. This will help your PMP get to know you and your health care needs. It may help you get care faster. Have all your past health records sent to your new health care provider.

If your PMP tells us that they are moving, retiring or leaving the CareSource network for any reason, we will let you know by mail within 30 days. We will assign you a new PMP or help you choose a new PMP from the CareSource network. We will also let you know if any of our network hospitals within your region are no longer in network.

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 CareSource sends or posts:

- 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.

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. We are an open network. Please remember you are able to get care from any network dental provider.

It’s easy to choose your Dental Home. You can do this by logging 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).

Remember, you can also earn rewards for completing routine dental exams. See the rewards section on page 44 to learn more.

WHERE TO GET CARE

Primary Medical Provider (PMP)

Your PMP is usually open during regular business hours. See your PMP for routine care, common illnesses and health advice. You will need an appointment. Your PMP is the doctor you will visit most often.

Telehealth

Telehealth is a convenient option for care. It can give you quick medical advice that can prevent your condition from getting worse. It may also lower your chance of exposure to illnesses like the flu. Your PMP may offer this service on your phone or computer. You can talk to your PMP from wherever you are.

There is no additional 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 sinus infections, allergies, rashes and more. You can also use it for follow-up visits.

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.

Connecting with Teladoc is easy!

- Visit www.Teladoc.com/CareSource.
- Call 1-800-TELADOC (835-2362) (TTY: 711).
- Access from the CareSource mobile app.
- Referral and direct connection from CareSource24.
- Download the Teladoc app on your smartphone.

Have your CareSource member ID number ready when you call. You will need to answer a few questions. The doctor will call you, often within 10 minutes.

Use Teladoc for many common health concerns, like:

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

You can also use Teladoc for mental health and substance use* concerns like those listed below. You can talk with a therapist or prescriber seven days a week, 7 a.m. to 9 p.m.

- Anxiety
- Depression
- Stress
- Substance use
- Trauma
- Relationship issues
- And more

*Must be 17 years of age or older

Note: Teladoc 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 seven 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

Urgent care facilities or clinics are open seven 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.

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. POWER Account money cannot be used to pay this copay. It will be waived if you speak to the CareSource24 Nurse Advice Line and are referred to the ER.

Follow-Up Care (Also Called Post-Stabilization 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**.

CareSource 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. CareSource will cover your post-stabilization care 24 hours a day, seven days a week.

We want to be sure you continue to improve. We want your condition to be stable and to resolve if possible.

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 after hours 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 ER:

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.

MAKE THE MOST OF YOUR PLAN BY USING THESE TOOLS

CareSource Website

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

Visit CareSource.com/IN to:

- Learn about services and how to get 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 in the Contact Us section 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
- 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 licensed expert with behavioral health training at **1-833-227-3464**. You can call 24 hours a day, seven days a week. You may also dial 988 to reach the 988 Suicide and Crisis Lifeline for any mental health concerns. 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 overwhelmed

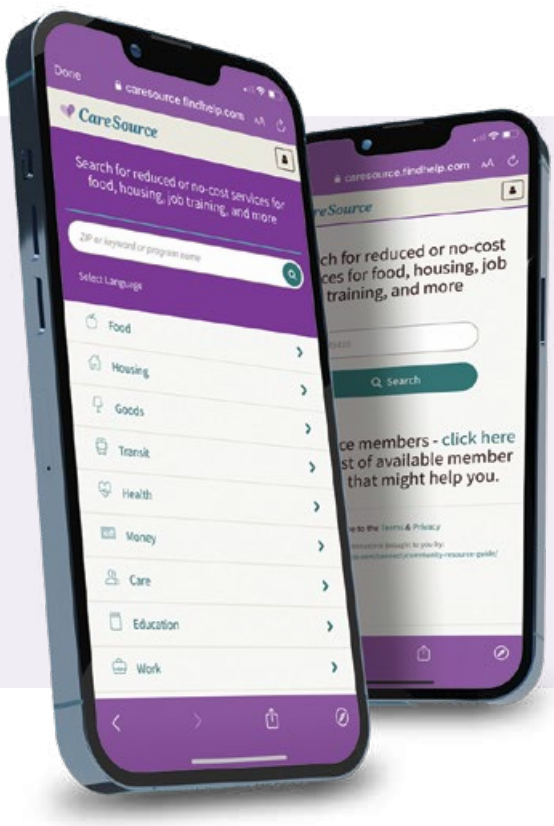
- Feeling anxious
- Feeling alone
- Feeling depressed
- Feeling like there is no reason for living
- Using or abusing drugs or alcohol
- Having dramatic mood changes

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
- Make your POWER Account Contribution (HIP Plus/HIP State Plan Plus plans only)
- Call and talk with Member Services
- Call the CareSource24 nurse advice line to talk with a nurse 24/7/365



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.

Finding a Doctor

You must use providers in the CareSource network. Visit **findadoctor.CareSource.com** to get the most up to date list or call Member Services. You will be able to learn more about in-network practitioners such as:

- Name
- Address
- Telephone Numbers
- Professional Qualifications
- Specialty
- Medical/Dental School Attended
- Residency
- Board Certification Status

You can also ask for a printed copy of the Provider Directory or call Member Services.

Explanation of Benefits

We will send an Explanation of Benefits (EOB) when you:

- Visit a health care provider
- 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
- 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

CareSource needs to pre-approve some services and prescription drugs. **Our pre-approval is a prior authorization.** Your health care provider will ask CareSource if a service needs pre-approval. Your provider can set up your visits once CareSource approves.

CareSource will not cover some services or prescription drugs without a pre-approval. You can see these on the charts on the next pages. Please call Member Services 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

This is not a complete list of services that need pre-approval. There may also be differences between the HIP and HHW plans.

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 Member Services 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	√
Dental*	√

**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. 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, give us a call. You can talk with Member Services so 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 following services do not need a referral from your Primary Medical Provider::

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

HHW Benefit Packages

The State will let you know if you are eligible for HHW. They will choose the right plan for you.

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.

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.

Type of Service	Package A	Package C	Prior Authorization Needed?
Doctor Visits	Yes	Yes	No
Early and Periodic Screening, Diagnostic and Testing (EPSDT)	Yes	Yes	No
Checkups	Yes	Yes	No
Chiropractors	Yes	Yes	Yes, after initial benefit is met.
Family Planning Services	Yes	Yes	No
Clinic Services	Yes	Yes	No
Nurse Practitioner Services	Yes	Yes	No

Type of Service	Package A	Package C	Prior Authorization Needed?
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.	No
Hospital Care (Non-Emergency)	Yes	Yes	Yes
Pharmacy and Medicine			
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.
Emergencies, Tests and Transportation			
Emergency Services	Yes	Yes	No
Lab and X-ray Services	Yes	Yes	No
Emergency Transportation	Yes	$10 copay for ambulance transportation	No Prior authorization needed for airline or air ambulance (can get after services are rendered). Please see Indiana Health Coverage Programs (IHCP) rules for medical necessity, special circumstances and hospital-to-hospital transfers.
Non-Emergency Transportation	Yes	No	No Trips over 50 miles require prior authorization.
Dental Benefits			
Oral Exams and X-rays	Yes	Yes	No
Dental Cleanings	Yes	Yes	No

Dental Benefits			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Other Preventive Services	Yes	Yes	No
Minor Restorative Services (ex: Fillings)	Yes	Yes	Some services require a prior authorization.
Major Restorative Services (ex: Dentures)	Yes	Yes	Some services require a prior authorization.
Periodontal Services	Yes	Yes	Some services require a prior authorization.
Extractions and Oral Surgery	Yes	Yes	Some services require a prior authorization.
Orthodontics (ex. Medically necessary braces)	Yes	Yes	Yes (Age and medical necessity criteria need to be met.)
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.			
Special Services			
Anesthesia (including dental)	Yes	Yes	Yes
Nursing Facility Services (Long Term)	Transition of Care up to 60 days.	No	Yes
Skilled Nursing Facility Services (Short Term)	Yes, less than 30 days.	No	N/A
Hospice Care	No*	No*	No
Nurse Midwife Services	Yes	Yes	No
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.	Yes
CareSource Life Services and CareSource JobConnect, support programs for non-medical barriers	Yes	Yes	No
Home Health Services	Yes	Yes	Yes
Stop Tobacco Use *Quit Now Indiana* **1-800-784-8669**	Yes	Yes	No

Special Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Education/Training Services	Yes	Yes	No
Non-Emergency Transportation	Yes	No	No
DME/Orthotics/Prosthetics	Yes	Yes	Yes

**CHIP 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	No Assessments and screenings do not require prior authorization. Diagnostic evaluations prior authorization is needed after one per benefit year.
Counseling	Yes	Yes	Yes, prior authorization is needed after 20 sessions (individual, family and group) per provider per 12 month period.
Psychiatry	Yes	Yes	No
Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes
Partial Hospitalization Program (PHP)	Yes	Yes	Yes
Medication Assisted Treatment (MAT)	Yes	Yes	Prior authorization is not needed for preferred drug. Yes, prior authorization is needed for non-preferred drug.
Withdrawal Management	Yes	Yes	Yes
Substance Use Disorder Residential Treatment	Yes	Yes	Yes
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	Yes

Therapies/Habilitative Services			
Type of Service	**Package A**	**Package C**	**Prior Authorization Needed?**
Applied Behavioral Analysis (for Autism Spectrum Disorder)	Yes	Yes	Yes
Speech Therapy	Yes	Yes	Yes
Respiratory Therapy	Yes	Yes	Yes
Occupational Therapy	Yes	Yes	Yes
Physical Therapy	Yes	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.

Copay – This is the amount you pay when you get a health care service.

Plan – This is the health coverage you get through CareSource

Personal Wellness and Responsibility (POWER) account—HIP members have a POWER Account. This is used to pay the first $2,50 in health care costs you have in a year.

POWER Account Contributions (PAC)—this is a monthly cost paid by HIP Plus and HIP State Plan Plus members.

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

There are five HIP plans. Read on to learn more about each plan.

HIP General Information

HIP covers all basic health benefits, like dental and vision. HIP has a Personal Wellness and Responsibility (POWER) account. You may also have low-cost monthly POWER Account Contributions (PAC) or copays. You do not pay any copays or PAC if you are:

- Pregnant (including 12 months postpartum)
- American Indian/Alaska Native

You will use POWER Account funds to pay for the first $2,500 of care you get each year. POWER Account funds cannot be used to pay for copays or PAC. Learn more in the HIP POWER Account section of this handbook.

1. 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. Instead, you make a monthly PAC based on income and family size.
- There are no copays in HIP Plus, except for $8 if you go to the ER for a non-emergency.
- You need to make your monthly PAC by the invoice's due date. If you stop paying, you may drop in benefits to HIP Basic or you could lose all benefits.

2. HIP Basic

- HIP Basic is a reduced plan. This is for members who do not pay their PAC and meet the income standards to keep benefits (100% and below the Federal Poverty Level (FPL)).
- It includes basic benefits that meet coverage rules. There is also a cost to you for each service.
- Anyone can upgrade to HIP Plus. This can be done at certain times of the year.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT).
- HIP Basic does not have standard vision or dental services. HIP Basic members age 19-20 can get EPSDT services, like vision and dental. Members 19-20 can also get some limited enhanced preventive and diagnostic dental services. It does not cover bariatric surgery or jaw care (TMJ).
- It has less visits to physical, speech and occupational therapies than HIP Plus.
- If you are enrolled in HIP Basic you are not required to make monthly contributions to a POWER Account. You will need to pay the copays shown in the table below at the time of service:

Service	Copay
Preventive care, maternity services or family planning services	$0
Outpatient services (Including Doctor Visits)	$4
Inpatient services (Including Hospital Stays)	$75
Preferred drugs	$4
Non-preferred drugs	$8

3. HIP Maternity

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

- Pregnant members do not have copays or monthly payments.
- HIP Maternity offers current benefits plus additional benefits during the HIP member's pregnancy and for an extra 12 months starting the first day of the month after the end of the 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.

HIP State Plans

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.

4. HIP State Plan Plus: Includes all HIP Plus benefits. You do not pay out of pocket for visits or prescriptions. Instead, you make a monthly PAC based on income and family size. In HIP State Plan Plus there are no copays, unless you go to the ER for a non-emergency. You need to pay by the invoice due date. The State may move you to HIP State Plan Basic if you stop making your payments. HIP State Plan Basic has copays.

5. HIP State Plan Basic: Also includes all HIP Plus benefits. Members in HIP State Plan Basic are not

required to make monthly contributions to their POWER Account, but must pay the copays shown in the table below at the time of service:

Service	Copay
Preventive care, maternity services or family planning services	$0
Outpatient services (Including Doctor Visits)	$4
Inpatient services (Including Hospital Stays)	$75
Preferred drugs	$4
Non-preferred drugs	$8

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 (also called pre-approval).

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	No
Early and Periodic Screening, Diagnostic and Testing (EPSDT)	Yes, for ages up to 21.					No
Checkups	Yes	Yes	Yes	Yes	Yes	No
Chiropractic Manipulation	Yes, limit 6 per year.	No	Yes, limit 6 per year.	Yes, limit 6 per year.	Yes, limit 6 per year.	No
Family Planning Services	Yes	Yes	Yes	Yes	Yes	No
Clinic Services	Yes	Yes	Yes	Yes	Yes	No
Nurse Practitioner Services	Yes	Yes	Yes	Yes	Yes	No
Hospital Care (Non-emergency)	Yes	Yes	Yes	Yes	Yes	Inpatient: Yes Outpatient: Yes
Pharmacy and Medicine						
Preferred Drug List (PDL) Drugs	Yes	Yes	Yes	Yes	Yes	Prior authorization needed for some drugs for step therapy, quantity or medical necessity.
Mail Order Prescriptions	Yes	Yes	Yes	Yes	Yes	No

Emergencies, Tests and Transportation						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
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.	No
Lab and X-ray Services	Yes	Yes	Yes	Yes	Yes	No
Emergency Transportation	Yes	Yes	Yes	Yes	Yes	No prior authorization needed for emergent ground transportation. Air transportation authorization may be obtained after the service is provided.
Mental Health and Substance Use Disorder (SUD) Services						
Assessments, Screenings & Evaluations	Yes	Yes	Yes	Yes	Yes	No. Diagnostic evaluations prior authorization is needed after one per benefit year.

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?**
Counseling	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization is needed after 20 sessions (individual, family and group) per provider per 12 month period.
Psychiatry	Yes	Yes	Yes	Yes	Yes	No
Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes	Yes	Yes	Yes
Partial Hospitaliza-tion Program (PHP)	Yes	Yes	Yes	Yes	Yes	Yes
Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes	Yes	No. Prior authorization is not needed for preferred drug. Yes. Prior authorization is needed for non-preferred drug.

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?**
Withdrawal Management	Yes	Yes	Yes	Yes	Yes	Yes
Substance Use Disorder Residential Treatment	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient Mental Health and Substance Use Disorder Treatment	Yes	Yes	Yes	Yes	Yes	Yes
Dental Benefits						
Oral Exams and X-rays	Yes	No*	Yes	Yes	Yes	No
Dental Cleanings	Yes	No*	Yes	Yes	Yes	No
Other Preventive Services	Yes	No*	Yes	Yes	Yes	No
Minor Restorative Services (ex: Fillings)	Yes	No*	Yes	Yes	Yes	Some services require a prior authorization.
Major Restorative Services (ex: Dentures)	Yes	No*	Yes	Yes	Yes	Some services require a prior authorization.

**HIP Basic members age 19-20 are eligible for (EPSDT) services and some limited enhanced preventive and diagnostic dental services. There are no copays for EPSDT. Limited dental services available for accident/injury.*

Dental Benefits						
	HIP Plus	**HIP Basic** *Copays may apply*	**HIP Maternity**	**HIP State Plus**	**HIP State Basic** *Copays may apply*	**Prior Authorization Needed?**
Periodontal Services	Yes	No*	Yes	Yes	Yes	Some services require a prior authorization.
Extractions and Oral Surgery	Yes	No*	Yes	Yes	Yes	Some services require a prior authorization.
Accident or Injury Related Dental Services	Yes	Yes	Yes	Yes	Yes	Some services require a prior authorization.
If dental services are to be performed in hospital or ambulatory surgical center, a prior authorization is required.						

**HIP Basic members age 19-20 are eligible for (EPSDT) services and some limited enhanced preventive and diagnostic dental services. There are no copays for EPSDT. Limited dental services available for accident/injury.*

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.	No
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	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
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.	Yes
DME / Orthotics / Prosthetics	Yes	Yes *With Enhanced Benefits	Yes	Yes	Yes	Yes
Home Health Services	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	Yes, 100 visits.	Yes
Hospice Care	Yes	Yes	Yes	Yes	Yes	Yes
Medical Supplies and Equipment (e.g. hearing aids, prosthetic devices, etc.)	Yes	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?**
Education and Training Services	Yes	Yes	Yes	Yes	Yes	No
Non-Emergency Transportation	Yes *Added CareSource Benefit	Yes *Added CareSource Benefit	Yes *With Enhanced Benefits	Yes	Yes	No
Therapies / Habilitative 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	Yes, prior authorization needed for some visits.
Speech Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.
Occupational Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.
Physical Therapy	Yes	Yes	Yes	Yes	Yes	Yes, prior authorization needed for some visits.

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 an important part of your overall wellness. We can help you whether you are struggling with depression, anxiety or substance use. Call Member Services or refer to your Provider Directory. Or use our Find a Doctor online tool at **findadoctor.CareSource.com**

CareSource Substance Use Hotline

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. OTP 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.

To apply for an OTP:

- **If you are 18 years of age and older,** you can apply for services if you have had an opioid use disorder 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 do not need to wait for one year to seek treatment if:

- You just left a penal institution and seek OTP services within 6 months of leaving
- You are pregnant
- You have been treated before and you seek treatment within two years after leaving

You can see a list of opioid treatment programs on **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).

SUD Residential Treatment Services

We are here to support you with Substance Use Disorder (SUD) residential treatment. These services need prior authorization. You can earn rewards for getting SUD services. See page 50 to learn more.

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

- Withdrawal management
- 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 designed just for you to help 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 supports 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. Support includes helping teens build healthy habits, develop communication skills, cope with stress, manage depression or anger and more.

BeMe Offers Science-Backed Support For Teens

- **Coaching:** BeMe coaches provide private, real-time, text-based support. They help teens learn and practice coping and resilience-building skills. They are even available on nights and weekends.
- **Content:** BeMe's teens always have access to supportive content developed by experts.
- **Crisis:** Teens have access to 24/7 support: Safety Planning, BeMe's Crisis Hotline, Crisis Text Line and The Trevor Project.
- **Care:** BeMe connects teens as needed to therapy from in-network CareSource providers.

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. - 5 p.m.

Therapies and Habilitative Services

Therapies and Habilitative Services help a person keep, learn, or improve skills for daily living. Therapies and habilitative 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.
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 an unlimited number of non-emergency rides for covered* health care visits during the year. You also have non-emergency transportation you are in HIP or HHW Package A for:

- Unlimited rides to the pharmacy after your visit with the doctor. You can now take 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.*

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 provided through a vendor. 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.
- Children under age 16 must always ride with an adult age 18 years or older.
- If you need a car seat(s), you must provide the car seat(s), or your trip will be canceled. If you need a booster seat, one can be provided for you.

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 us.

INCENTIVES AND REWARDS

Make healthy choices and earn rewards! You and your family can earn rewards for working to improve your health. Earn rewards for activities like going to your yearly wellness visit or getting certain types of preventive care. Learn more about rewards in the lists below. You can also visit HHW Benefits or HIP Benefits at **CareSource.com/IN** to learn more.

How to Use Your Rewards

- Your provider tells us you or your baby has done an activity
- We add your reward to your account
- Use your rewards card to buy items (or gift cards with MyHealth) through the stores that are part of the program
- You will get a list of stores with your rewards card

Rewards Portal
Our rewards portal is called MyHealth. MyHealth is how you will keep track of your rewards. Go to the MyHealth Rewards section below to learn more.

If you do not have access to the internet or portal, we can help. Call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711). Our staff can help you register and redeem your rewards.

Babies First®

As an expecting or new mom, you and your baby can earn up to $240 in rewards with the Babies First program. You should see your doctor regularly while you are pregnant. See your doctor for a follow-up exam after your baby is born. Your child should also go to all their well-child visits with the doctor.

You must sign up for Babies First each time you are pregnant. It's easy to do. Fill out the Babies First Registration Form on https://www.caresource.com/in/plans/medicaid/benefits-services/rewards/ or call Member Services. This list shows how you and your baby can earn rewards.

2024 Babies First Rewards* Summary		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
During pregnancy (Prenatal) visits	Pregnant females	1st visit $50 5th visit $25
After baby (Postpartum) visit	New mothers	$40 per pregnancy
Additional after baby visit	New mothers	$15 per pregnancy
Six well-baby visits in 15 months	Babies up to 15 months	$15 per visit
Lead screening	Babies up to 15 months	$ 20 – 1 time
Health Needs Screening (HNS)	New members within 90-days of joining	$30 Walmart gift card

*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.

If you are pregnant and 18 years or older you can also join the MyHealth Rewards program. If you are pregnant and 17 years and under you can also join the Kids First Rewards program. To learn more about Kids First and MyHealth see below or visit ***MyCareSource.com****.*

Kids First

Kids First lets your child ages 16 months through 17 years earn rewards for healthy lifestyle activities. Each child can earn up to $50 for doing healthy activities. These include a yearly physical, vaccines, and routine dental exams. Rewards vary based on your child's health and wellness needs. You can sign your child up by filling out the Kids First registration form on **MyCareSource.com** or calling Member Services.

How to Use Kids First Rewards

- Your provider tells us your child has done an activity
- We add your reward to your Kids First account
- Use your rewards card to buy items through the stores that are part of the program
- You will get a list of stores with your rewards card

Here are ways your child can earn rewards.

2024 Kids First Rewards* Summary		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
Routine Dental Exam	Children ages 16 months through 17 years	$10 2x / calendar year
Well-Child Visit: 16 Months through 30 Months	Children ages 16 months through 30 months	$10 3x / calendar year
Well-Child Visit: 3 Years - 17 Years	Children ages 3 years through 17 years	$20 1x / calendar year
Lead Screening	Children ages 15 months through 6 years	$20 1x / calendar year AND 2x/ lifetime
Well-Child Vaccinations (Dtap, IPV, MMR, and Varicella - given as a series)	Children ages 4 years through 6 years	$20 1x / calendar year
Well-Child Vaccination - Tdap	Children ages 11 years through 17 years	$10 1x / calendar year
Well-Child Vaccination - HPV Series (given as a series)	Children ages 11 years through 17 years	$30 1x / calendar year
Well-Child Vaccinations - Meningococcal	Children ages 11 years through 17 years	$10 1x / calendar year
Yearly Flu Shot	Children ages 16 months through 17 years	$10 1x / calendar year

ADHD Follow-up Visits within 30 days of Initial Prescription	Children ages 16 months through 17 years diagnosed with ADHD	$10 1x / calendar year
ADHD Follow-up Visits within 10 months of initial prescription	Children ages 16 months through 17 years diagnosed with ADHD	$10 2x / calendar year
Health Needs Screening	New members only within 90 days of enrollment.	$30 Walmart® gift card

*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.

MyHealth Rewards for Adults

MyHealth is our online wellness program. MyHealth is available to all adult members at no extra cost. You can earn rewards for doing healthy activities. All adult members are signed up for MyHealth. You do not need to sign up. Go to **MyCareSource.com** and go to the *Health* tab to get to MyHealth. You can keep track of your rewards points here.

How to Use MyHealth Rewards

- Your provider tells us you have done an activity
- We add your reward to your MyHealth account
- Use your rewards card to buy gift cards through the stores that are part of the program
- You will get a list of stores with your rewards card

HIP and HHW members can earn up to $300 in rewards each year.

HHW Members:

- Your $300 could made up of:
  - Up to $50 in Wellness and Preventive Rewards
  - Up to $200 in Chronic Disease Management Rewards
  - Up to $200 in Tobacco Cessation and Substance Use Rewards

HIP Members

- Your $300 could be made up of:
  - Up to $50 in Wellness and Preventive Rewards
  - Up to $200 in Chronic Disease Management Rewards
  - Up to $200 in Tobacco Cessation and up to $100 for Substance Use Rewards

MyHealth also has a tool called Journeys. With Journeys you can:

- Track exercise goals
- Better understand health and wellness topics that matter to you
- And more!

Here are ways you can earn rewards.

2024 MyHealth Wellness and Preventive Rewards* Summary

HHW Adult Members earn up to $50 in Wellness and Preventive Rewards
HIP Members earn up to $50 in Wellness and Preventive Rewards

2024 MyHealth Wellness and Preventive Rewards* Summary HHW Adult Members earn up to $50 in Wellness and Preventive Rewards HIP Members earn up to $50 in Wellness and Preventive Rewards		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
Yearly Dental Exam	All adults ages 18 through 64	$10 2x/calendar year
Yearly Physical Exam	All adults ages 18 through 64	$20 1x/calendar year
Yearly Flu Shot	All adults ages 18 through 64	$10 1x/calendar year
Breast Cancer Screening (Mammogram)	Females ages 50 through 64	$20 1x/calendar year
Chlamydia Screening	Females ages 18 through 25	$10 1x/calendar year
Cholesterol Screening	Males ages 35 through 64 Females ages 45 through 64	$10 1x/calendar year
Cervical Cancer Screening (Pap Smear)	Females ages 18 through 64	$10 1x/calendar year
Complete a Journey in MyHealth	All adults ages 18 through 64	$5 3x/calendar year
HPV Vaccine (given as a series)	Males and Females ages 18 through 26	$10 for the series
Indiana Health Needs Screening Completion	All adult new members within 90 days of eligibility Ages 18 through 64	$30 - Walmart gift card. See pages 8-9 in the **Quick Start Guide** for details on how to complete the Health Needs Screening. Must be completed within first 90 days of enrollment.
Pneumococcal Vaccine	All adults ages 18 through 64	$10 1x/calendar year
Vaccination - Tetanus-Diphtheria Booster	All adults ages 18 through 64	$10 1x/calendar year

You may also be able to earn a reward for getting your COVID-19 vaccine. Adults ages 18 years through 64 years may earn $50 after their 2nd dose of Pfizer or Moderna, or after a Johnson & Johnson single dose.

** 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.*

2024 Chronic Disease Management Rewards HHW Adult Members earn up to $200 in Chronic Disease Management rewards for Diabetes Testing. HIP Members earn up to $200 in Chronic Disease Management rewards.		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
ADHD Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with ADHD	$15 3x/calendar year
Asthma Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with asthma	$15 4x/calendar year
CAD Beta-blocker Adherence Post AMI or Other Cardiac Event	All HIP and HHW adults ages 19 through 64 diagnosed with CAD	$15 4x/calendar year
CAD and DM Statin Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with CAD	$15 4x/calendar year
CHF Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with CHF	$15 4x/calendar year
Comprehensive Prenatal Risk Assessment	All HIP and HHW adult pregnant females ages 19 through 64	$25 1x/calendar year
Continuation of Care Management	All HIP and HHW adults ages 19 through 64 *Must have qualifying health needs classification.*	$20 3x/calendar year
COPD Corticosteroid Adherence Post-Acute Care Event	All HIP and HHW adults ages 19 through 64 diagnosed with COPD	$15 1x/calendar year
COPD Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with COPD	$15 4x/calendar year
Depression (Major) 7-Day Follow-up Appointment After Hospital Discharge	All HIP and HHW adults ages 19 through 64 diagnosed with depression	$40 1x/calendar year
Depression (Major) Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with depression	$15 4x/calendar year
Diabetes Medication (all classes) Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with diabetes	$15 4x/calendar year
Diabetes A1C Testing	All adults ages 18 through 64 diagnosed with diabetes	$25 1x/calendar year

2024 Chronic Disease Management Rewards HHW Adult Members earn up to $200 in Chronic Disease Management rewards for Diabetes Testing. HIP Members earn up to $200 in Chronic Disease Management rewards.		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
Diabetes Micro-Albumin Testing	All adults ages 18 through 64 diagnosed with diabetes	$25 1x / calendar year
Diabetes Retinal Eye Exam	All adults ages 18 through 64 diagnosed with diabetes *Exam must be performed by a specialty eye care provider.*	$10 1x/calendar year
Hepatitis C Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with Hep C	$15 4x/calendar year
HIV Medication Adherence	All HIP and HHW adults ages 19 through 64 diagnosed with HIV	$15 4x/calendar year
HIV Viral Load Test	All HIP and HHW adults ages 19 through 64 diagnosed with HIV	$10 1x/calendar year
Maternal Depression Screen (within 6 months of giving birth)	All HIP and HHW adult postpartum females ages 19 through 64	$40 1x/calendar year
Initiation of Care Management	All HIP and HHW adults ages 19 through 64	$25 1x/calendar year
Continuation of Care Management	All HIP and HHW adults ages 19 through 64 *Must have qualifying health needs classification*	$20 3 2x / 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.*

2024 Tobacco Cessation and Substance Use Rewards* HHW Adult Members earn up to $200 in Tobacco Cessation and Substance Use Rewards HIP Members earn up to $200 in Tobacco Cessation and up to $200 in Substance Use Rewards		
Rewardable Program Activity	**Who's Eligible**	**Rewards***
Behavioral Counseling Continuation at 6 Weeks for Tobacco Cessation	All HIP and HHW adults ages (19 through 64)	$20 1x/calendar year
Behavioral Counseling Initiation for Tobacco Cessation	All HIP and HHW adults ages (19 through 64)	$30 1x/calendar year
IN Tobacco Quit Line Engagement in Cessation Coaching	All HIP and HHW adults ages (19 through 64)	$50 1x/calendar year
IN Tobacco Quit Line Engagement in Cessation Coaching While Pregnant	All HIP and HHW adults ages (19 through 64) who are pregnant	$80 1x/calendar year
IN Tobacco Quit Line Additional Cessation Coaching Calls	All adults ages 18 through 64	$10 9x/calendar year
Substance Use Disorder (SUD) Intensive Outpatient Treatment (IOT) Session	All HIP and HHW adults ages (19 through 64)	$10 10x/calendar year
Tobacco Cessation Medications (1st, 4th, 8th and 12th weeks)	All HIP and HHW adults ages (19 through 64)	$20 4x/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.*

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.

- **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
- Inhaler spacers
- Peak flow meters
- Syringes
- Needles
- Alcohol wipes
- Condoms

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

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 also 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. Many alternative drugs work like other drugs with like side effects.

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/refill a prescription drug.

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.

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. If a brand-name product is requested when a generic equivalent is available, your provider will need to ask for a prior authorization.

Medication Therapy Management (MTM) Program

Correct prescription drug use is vital to your health. Medication Therapy Management (MTM) is a program for you to learn about your drugs. It will help stop or focus on prescription drug-related problems and lowers costs. It can help you stick to your plan.

You can work with a local pharmacist or a CareSource pharmacist for MTM. Your pharmacist will get alerts and information about your drugs. 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. The pharmacist will help you with your drugs and how to take them. They will work with your health care provider to help you and improve your prescription drug use. You get this service at no cost to you.

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 some drugs before they are covered. This is called a prior authorization (or pre-approval). Your provider will tell us why you need a certain prescription drug and/or a certain amount of a drug. We must approve the request before we will cover the drug. Here are some reasons a pre-approval 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 pre-approval. You can also call us to ask about our PDL, and which drugs or services need pre-approval.

Prior Authorization Exceptions

There may be reasons you are not able to take a drug. In these cases, you may ask for a different drug to be covered. This is called an exception for prescriptions. 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

You or someone acting for you can make an exception request. We will work with your provider if they ask for this for you.

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. They can also be misused. Most people who misuse prescription drugs often get them from friends or family. 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

Our Care Managers can help you better understand your health and how to care for yourself. We have Care Management for children and adults. The Care Management team has registered nurses, behavioral health professionals, and other outreach workers. 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. Be sure to see how you can earn rewards by completing health activities that help you manage chronic conditions. Go to the rewards section of this handbook to learn more.

A Case Manager may contact you when:

- You ask them to
- 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 for pregnant Medicaid members who use opioids or have used opioids in the past. The program can connect you to prenatal and postpartum care, other physical and mental health care, and treatment for opioid use disorder. The program provides support during the prenatal period and for 12 months after the end of pregnancy. It also has childcare benefits for all enrollees. You can join this free program here: **https://appengine.egov.com/apps/in/promise**

Right Choices Program (RCP)

The Right Choices Program (RCP) is a state directed program. Members are referred to this program when they use Medicaid services more than other members. If you are enrolled in RCP, you will be sent a letter explaining the program. You are assigned one primary medical provider and one pharmacy you must see unless you have an emergency. If you are in RCP, you have one CareSource Care Manager assigned to you. They will help you manage your care and ensure your needs are being met. Call your assigned Care Manager with any questions.

High Risk Care Management

We offer services for complex health needs. We have a High Risk Care Management team. They may work with you one-on-one by phone and in person. They can help you learn about your health and manage your care. Call Member Services if you have questions or think you may need high risk care management.

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. The member assistance program has a fund that can help you remove barriers that prevent working and/or meeting basic needs. At least 3 tries are made to find existing 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 maximum member benefit is $200 per year (Jan-Dec). Areas of support may include:

- 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 MyHealth online tool 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 them 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. 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**.

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 impair 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.

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.

EPSDT For Children: Birth to Age 21

Early and Periodic Screening, Diagnostic and Treatment (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)
- Medical follow-up care to treat health issues
- Blood lead level 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 36 months and 72 months must get a blood lead test if they have not been tested for lead poisoning before.

Schedule an EPSDT Visit with Your Primary Medical Provider (PMP)/Primary Dental Provider (PDP)

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 more care is needed.

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.

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.

Definitions of 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 once 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 21-64 should get a cervical cancer screening, called a pap smear, every 3 years.
- **Breast Cancer Screen:** Women between the ages of 40 to 75 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.
- **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

Indiana Health Coverage Programs (IHCP) let you 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. HIP Maternity members do not have to pay Power Account Contributions (PAC) or pay copays. Follow these steps to get all your extra pregnancy benefits:

Step 1: Report your pregnancy to CareSource 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. This will stop any POWER Account payment or copays while you are pregnant.

Step 2: You will get HIP Maternity benefits after you report your pregnancy. 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 health care 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 and then more often during the last trimester. This can help spot any problems before they become serious and avoid problems during birth.

Step 4: It's vital 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 **1-844-607-2829** (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. You still do not have to make any payments or copays during this time. Please call us if you have any questions.

Step 5: After the 12 month postpartum period you may transfer off HIP Maternity. If you are eligible you may move to HIP Basic. Or you can make a payment within the 60-day period on your invoice to get HIP Plus benefits. We will send you an invoice that tells you about your PAC and how to pay. You can also call us if you have any questions.

Special Programs for Pregnant Members

Babies First

We offer a free program to pregnant women and new moms called Babies First. See the Babies First part of this handbook to learn more.

Text4Baby

You may have many questions about your pregnancy and newborn baby. Text4Baby can help you. Sign up to get texts with health and safety tips. These texts will be sent while you are pregnant until your baby is one year old. Visit **text4baby.org** to sign up.

Mom and Baby Beginnings

The Mom and Baby Beginnings program has many types of staff to help you have a healthy pregnancy. Staff includes nurses, socials workers, behavioral health, substance use case managers and breastfeeding specialists. If you would like to learn more about this program can help you, please call **1-833-230-2034**.

Infant Scales for NICU Babies

Some high-risk infants need their weight checked often for the first few weeks or months. This can be vital for their continued health. 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 as risk members. Please call us if your baby was in the NICU or talk to your care manager to learn more.

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 monitoring your baby's growth and development
- Enhanced opportunity to get feedback during a telehealth visit
- Avoid emergency room visits that aren't needed

If you would like an infant scale for your baby, call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to learn more.

CARESOURCE REENTRY PROGRAM™

Getting back on your feet after being jailed or in prison can be a challenge. You may not have the support you need to get back on your feet. It can be hard to find safe housing, food, and health care. You may also face mental health issues or struggle with substance use.

Nearly one in three people will return to prison within three years of release without proper support. 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

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 vital 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 legal help
- Support from the CareSource team

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 reaching your goals. We can help pave the way from where you are to where you want to be. 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 support for:

- Transportation
- Access to food
- Budgeting and finance assistance
- Legal assistance
- Housing
- 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 helps you get new skills, links you with local services and helps you find a job. You'll be paired with a Life Coach who 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 member assistance. The member assistance fund can help you remove barriers that prevent working and/or meeting 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 available to CareSource members enrolled in CareSource Life Services. Other limitations will apply to funds as CareSource follows all State and Federal laws that apply.

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. You can access this tool by logging into your **MyCareSource.com** account. 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 Case 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
Additional calls with Quitline up to 9	$10	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/pregnant.**

Rewards for Stopping Tobacco Use

CareSource offers you rewards when you stop smoking. See the 2023 Tobacco Cessation and Substance Use Rewards chart in the **Incentives and Rewards** section of this handbook for a full list.

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

HIP POWER ACCOUNT (PERSONAL WELLNESS AND RESPONSIBILITY)

WORDS TO KNOW:
Enrollment broker: This is a person that can help you enroll in a health plan.

If you are a HIP member, you have a special savings account. **This is called a Personal Wellness and Responsibility (POWER) Account.** The first $2,500 of your health costs will be paid for with your POWER Account.

Things to know about your POWER Account if you have one:

- Your POWER Account is charged each time you get health care services.
- We will keep paying for your services, even if you use all of the money in your POWER Account before the year ends.
- You must renew your health care coverage each year. This is how you get a new $2,500 added to your account in January.
- We keep track of the money in your POWER Account. We will send you a monthly statement.

POWER Account Contribution (PAC)

If you are a HIP Plus or HIP State Plan Plus member, you will pay a POWER Account Contribution (PAC) each month. The amount you pay for your PAC varies by person. You may pay $1, $5, $10, $15 or $20 per member per month. You can learn more in the table below. You pay based on income and family size based on the Federal Poverty Level (FPL). The next section talks more about the tobacco surcharge.

PAC Tier Table

Tier Name	FPL*	Monthly PAC Single Individual	Monthly PAC Spouses (Each)	PAC With Tobacco Surcharge (see below)	Spouse PAC When One Has Tobacco Surcharge	Spouse PAC When Both Have Tobacco Surcharge (each)
Tier 1	Up to 22%	$1	$1	$1.50	$1 & $1.50	$1.50
Tier 2	23-50%	$5	$2.50	$7.50	$2.50 & $3.75	$3.75
Tier 3	51-75%	$10	$5	$15	$5 & $7.50	$7.50
Tier 4	76-100%	$15	$7.50	$22.50	$7.50 & $11.25	$11.25
Tier 5	101-138%	$20	$10	$30	$10 & $15	$15

** Federal Poverty Level. The Federal Poverty Level (FPL) is updated every year in late January. You can see the full FPL chart at **https://www.in.gov/fssa/hip/helpful-tools/federal-poverty-level-income-chart/**.*

Tobacco Use Surcharge

You will be charged an extra 50% on your POWER Account Contribution (PAC) each month if you are a HIP member and a tobacco user. This is called a tobacco surcharge. You have a full 12 months (based on a calendar year) to stop using tobacco before the surcharge can be added.

A tobacco user has used tobacco four or more times a week in the last six months. This includes chewing tobacco, cigarettes, cigars, pipes, hookah, snuff and vaping.

Tell us that you use tobacco on your application or call us to let us know. There are tobacco use questions on the Health Needs Screening. These answers will not impact your eligibility.

Go to **CareSource.com** to learn more about how we can help you quit using tobacco and how you can earn rewards. Please let us know if you quit using tobacco.

Tobacco Surcharge Questions and Answers

Q. When does the 50% tobacco surcharge get added to my PAC?

A. The first tobacco surcharge is added to PAC invoices. This starts the January after you join HIP. It is added if you have used tobacco for 12 months.

Q. How do I stop the surcharge once it gets added to my PAC?

A. Call Member Services anytime. You can also call the enrollment broker between November 1 and December 15 to let us know you have quit using tobacco This will stop the surcharge for the following January.

CareSource: **1-844-607-2829** (TTY: 1-800-743-3333 or 711)
Enrollment Broker: 1-877-438-4479 (GET-HIP9)

The State may check member claims about their tobacco use. Contact Member Services anytime to let us know if you have stopped using tobacco.

For more information, login to your online benefits portal at **www.fssabenefits.in.gov**.

Tracking and Rolling Over Your Power Account

Tracking and Rollovers
You should track the funds in your POWER Account. Your yearly health care costs could be less than $2,500 per year. The amount left in your POWER Account may lower your POWER Account Contribution (PAC) for next year. If there is money left in your account for the next year, it is called a rollover. Any money that rolls over can be used toward the next year's PAC. This can reduce how much money you owe for HIP Plus next year.

Preventive Care
The State will double your rollover funds if you get suggested preventive health care. The preventive care charts in the **Preventive Care: Children, Women, and Men** section of this handbook can help you know what kind of care you might need.

Moving from HIP Basic to HIP Plus
If you are a HIP Basic member with rollover funds and preventive services, you can move to HIP Plus. HIP Basic members You can use rollover funds to upgrade to HIP Plus. You will also have a lower PAC.

Why upgrade to HIP Plus? With HIP Plus you get more benefits, including services like dental, vision, and chiropractic services.

Making Payments on Time

You need to pay your monthly PAC on time to keep your benefits. If you do not, you may have reduced benefits. You can also prepay on your POWER Account.

How to make a payment:

1. **Pay Online:** This is a free Pay by credit card, debit card, or bank transfer. You can pay online each month, or you can set up an automatic monthly payment. You will need to sign in to your My CareSource account to pay your bill. Go to **MyCareSource.com** to sign up for an account.
2. **Pay by Phone:** This is a free service. Call **1-844-607-2829** (TTY: 1-800-743-3333 or 711) to make your PAC. You can use a credit card, debit card or bank transfer.
3. **Mail your Payment:** Make checks or money orders payable to CareSource and mail to the address below. You can also mail cash. Please include your member ID (MID) number on the check. You should also include the payment coupon from your monthly invoice. This will ensure payment is posted to your account.

   CareSource
   P.O. Box 6065
   Indianapolis, IN 46206-6065
4. **Pay by Payroll Deduction:** Ask your employer if they offer payroll deduction for health insurance contributions. You can set up payroll deduction for your POWER Account Contribution if they do offer it.
5. Go to **CareSource.com/in/members/tools-resources/forms/Medicaid/** to find the forms you need. You can also call us to ask for a copy of the form. Fill it out and send it back to us. We will work with your employer to set up a payroll deduction. This form lets us work with your employ. It does not automatically enroll you in payroll deduction.

HIP Earning Levels	If You Don't Pay Your PAC On Time
HIP Plus members earning less than Federal Poverty Level (FPL) (100% and below FPL)	HIP Plus members earning less than the FPL and who stop making monthly PAC will be moved to HIP Basic*.
HIP Plus Members earning more than FPL (above 100% FPL)	HIP Plus members earning more than the FPL who stop making their monthly PAC will lose their coverage. Members who lose their HIP Plus coverage may qualify for an exemption. They will need to reapply and return the exemption form sent by the Division of Family Resources (DFR). Exemptions include: • Loss of private insurance • Decrease in income • Had residence in another state and came back • Victim of domestic violence • Living in a county subject to a disaster declaration • Medically frail
HIP State Plan Plus members earning Less than FPL (100% and below FPL)	HIP State Plan Plus members earning less than the FPL and who stop making monthly PAC will be moved to HIP State Plan Basic.
HIP State Plan Plus Members earning more than FPL (above 100% FPL)	Medically frail HIP State Plan Plus members earning above the FPL and who stop making monthly PAC will keep coverage, but will need to make copays and will be billed for their monthly PAC contribution. This is called HIP State Plan Plus Copays.
*HIP Basic does not have standard vision, dental or chiropractic services. You will also need to pay copays for most health services. If you have questions about paying for and using your POWER Account, please call Member Services at **1-844-607-2829** (TTY: 1-800-743-3333 or 711).	

Third Party POWER Account Contributions

Other third parties (Churches, etc.) can contribute to your POWER Account. They can make a monthly payment or a lump sum payment up to your total yearly contribution. CareSource will apply the payment within 2 days. You must pay any remaining balance.

A third party has 60 days to contribute to your POWER Account. If they do not make the promised contribution, you must pay the full amount. You will have an additional 60 more days to make the contribution. Please visit **www.caresource.com/hippay** for more information.

Cost Share Limits

What is cost sharing?
Cost sharing is when you pay for certain parts of the costs for your insurance coverage (like your PAC or a copay) and CareSource pays for certain parts. You and CareSource share the cost.

You should pay no more than 5% of household earnings as part of cost sharing. This is a cost share limit. We will let you know if you go above this amount. We check cost share each quarter (every 3 months) and will tell you if you have met it. Your PAC invoices will show what you owe each month.

Here are how meeting cost share limits affects what you pay

- If you're a **HIP Basic or State Plan Basic member** and you reach the 5% cost share limit, you will not pay copays
- If you're a **HIP Plus or HIP State Plan Plus** and you reach the 5% cost share limit, your PAC will only be $1 per month until the next quarter starts.
- If you pay a tobacco use surcharge, you will owe $1.50

Pregnant women and American Indian/Alaska Natives do not have copays or PAC.

ELIGIBILITY AND ENROLLMENT

WORDS TO KNOW:
Benefit Year: January – December. Your benefit limits and POWER Account reset each January.
Eligibility Period: The months you have full coverage and benefits.

Changing Health Care Plans

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

Changing Plans for Cause (HIP)/Just Cause (HHW)

You have the right to change plans if you have a just cause. Just cause is an approved reason. For example:

- The plan does not, because of moral or religious objections, cover the service sought
- You need related services to be performed at the same time, but not all related services are available within the provider network; and primary medical provider or another health care provider determines that receiving the services separately would subject member to unnecessary risk
- Failure of the Contractor to comply with established standards of medical care administration
- Significant language or cultural barriers
- Corrective action levied against the Contractor by the office
- Limited access to a primary care clinic or other health services within reasonable proximity to where you live
- A determination that another MCE's formulary is more consistent with your existing health care needs
- Lack of access to medically necessary services covered under the Contractor's contract with the State
- Your primary health care provider disenrolls from your current MCE and reenrolls with another MCE
- If you were not given the opportunity to select an MCE in open enrollment you may change your MCE during the first 60 days of the new benefit period
- A change in aid category
- Other circumstances determined by the State or its designee to constitute poor quality of health care coverage
- Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experience in dealing with 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 assist 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

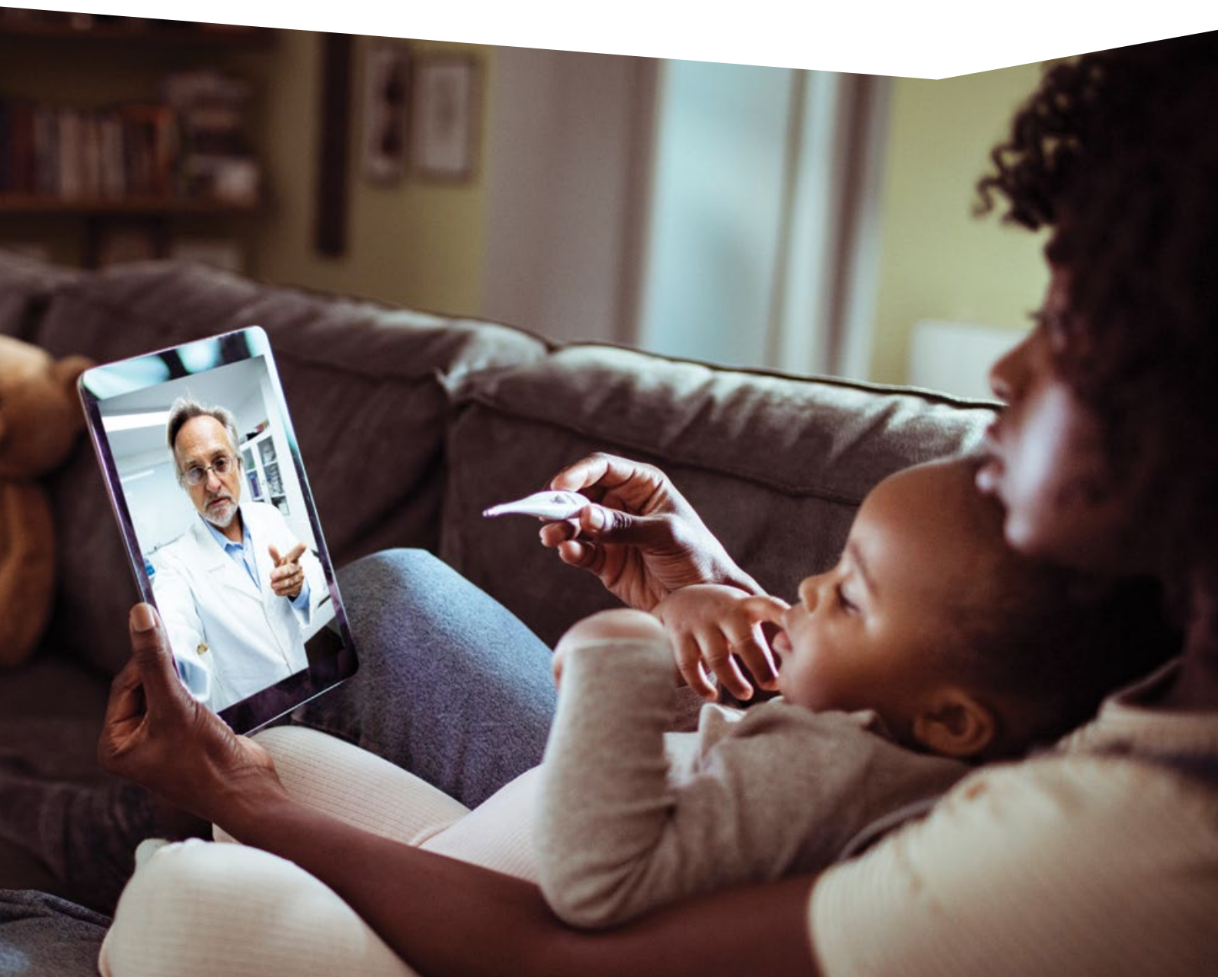
Note: A change could mean the loss of your other health insurance or could cause other changes to your insurance coverage.

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
- To ask for information about provider incentives. CareSource will provide this information to you if you ask for it.

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 service
- Treatment that our members get

Call the UM team if you have questions about how we review your care. Call Member Services and 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.

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

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 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 a you 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.

What is an appeal? If you do not agree with a decision we make to deny a service or benefit claim, you can file an appeal. You can also appeal when we only approve part of a claim. You have 60 days 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. CareSource will send a letter when we deny a services 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 or timely appeal answer
- 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, such as cost sharing

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 the appeal decision to you and your health care provider/facility. 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 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, 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
402 W. Washington St., Room E034
Indianapolis, IN 46204-227 OR

Phone: 1-317-232-4405

What to Expect at a State Fair Hearing

The Office of State Administrative Hearings 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

HIP and HHW Members, 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 final 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 additional information related to your issue:)
Please write a description of the grievance or appeal giving us as much detail as possible including the provider's information if your issue concerns a provider. You may attach additional pages, if needed.

(Member Signature)	**(Date)**

Should 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.

  o 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.

  o 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 action

- 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)

MEMBER CONSENT/HIPAA AUTHORIZATION FORM

Consent to Share Health Information

The CareSource policy is to share your health information. This includes Sensitive Health Information (SHI) such as drug and/or alcohol care, genetic testing results, HIV/AIDS, Sexually Transmitted Diseases (STD), or problems that are a danger to your health. We share this for the purpose of treatment, care coordination, and help with benefits. It is shared with your past, present, and future health care providers and the Health Information Exchanges (HIE). You have the right to tell us if you do not want your health information (including SHI) shared. This excludes the health care provider who treats you for the specific SHI. Your health care providers may not be able to coordinate your care if you don't allow sharing.

Member Consent/HIPAA Authorization

This form lets CareSource Management Group® and its affiliated health plans ("CareSource"), share your health information as described below. All of this form must be filled out. Mail or fax it to the address listed at the end of this form. Or, you may choose to fill out this form online at www.caresource.com.

Section 1: Member Information

Member Last Name	MI	Member First Name	Member Date of Birth

Member Street Address	City	State	Zip Code

Member Home Phone	Member Cell Phone	Member ID Number (Found on Plan ID Card)

By giving your cell phone number, you are saying that CareSource may use it to contact you.

Section 2: Consent to Share Health Information

This Member Consent/HIPAA Authorization Form provides your consent to share your health care information with others. This information is shared to help with your care and treatment, or to help with benefits. Your health care information may be shared with any past, current, or future providers you've seen for care. It also may be shared with some Health Information Exchanges (HIE). An HIE lets providers view health information that CareSource has about members. You also can share your health information on your own health care apps. You have the right to ask for a list of everyone who was given your health information by CareSource.

☐ Check this box if you want your health information to be shared with the past, current, and future providers you've seen for care, or your personal health care apps. The information will be shared for treatment, to manage your care, and to help with benefits. The information shared will include sensitive health information, including treatment for substance use and HIV/AIDS. For your personal health care apps, you will have more control over the information shared when you install it.

Or –

☐ Check this box if you **do not want** your health information to be shared with past, current, and future providers you've seen for care. The information will not be shared for treatment, to manage your care, or to help with benefits. None of your health information will be shared with your providers, with these exceptions:

- Due to state requirements we must follow, your Primary Medical Provider (PMP) may get a report that includes physical and behavioral health treatment you may have received. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.
- Due to other requirements we must follow, your health information may be shared with a HIE. It will not include substance use or HIV/AIDS information unless you checked the box above saying you want to share your health information.

If you do not approve sharing, your providers may not be able to manage your care as well as they could if you did approve sharing.

Section 3: Representative Designation

If you would like to name someone that CareSource may speak to on your behalf, please fill out this section. CareSource will share all of your health information with the person you name. If you name a group, like a law firm, the group is called an entity. Please give the entity's info and the name of a contact person at the entity.

Last Name	First Name	MI	Entity Name (if law firm or other entity)

Street Address	City	State	Zip Code

Home Phone	Cell Phone

Section 4: Review and Approval

By signing my name, I agree:

To let CareSource share my health information as marked in Sections 2 and/or 3. I agree that signing this form is my choice. I agree the information shared may be subject to being shared again by the person or entity receiving it. After that it may no longer be protected by federal privacy laws. Substance use disorder information from specific treatment programs (42 CFR Part 2), may be kept private and not allowed to be shared again without my permission. I agree this form is not making a Health Care Power of Attorney. I agree that I may cancel this permission at any time. To cancel permission, I must send a written letter to CareSource. I can send the letter to the address at the bottom of this form. I can also fax it to the number at the bottom of this form. Or, I may cancel my permission on www.caresource.com. I agree that if I cancel this permission, it will not change any actions CareSource took before I cancelled permission. I agree that my treatment, payment, enrollment or eligibility for benefits do not depend on whether I sign this form. ***Please sign below.***

Member/Minor Member's Parent Signature or Designated Legal Representative Signature*:	Date:

Date this Permission Ends: *If no date given, the permission will remain on your record unless/until you ask us to cancel it. For minor members, it will end on their 18th birthday.*
**If signed by someone other than the member/minor member's parent, that person must be a designated legal representative. A designated legal representative is someone who has been given the authority to act on the behalf of the member. If you have not already done so, you must provide a copy of the Power of Attorney or court papers that prove the person is a designated legal representative. Also complete these fields:*

Legal Representative (print full name)	Legal Relationship to Member, e.g., Power of Attorney, Court-Appointed Guardian or Custodian:		

Legal Representative's street address	City	State	Zip code

Please send your completed form to:
CareSource, Attn: Privacy Office, P.O. Box 8738, Dayton, OH 45401-8738, ***or***,
Fax it to 1-833-334-4722, ***or***,
you may choose to fill out this form online at www.caresource.com.

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 became too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to 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/**

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 or 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 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 CareSource24, our 24-hour nurse advice line, is available to help you. You can call the number on your member ID card, 24/7/365.

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.

- 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.

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 benefits
- 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: **1-844-607-2829** (TTY: 1-800-743-3333 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 give us as much information 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 information 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 **1-844-607-2829** and choose the "report fraud" menu option.

WORD MEANINGS

Advance Directives or Living Will – A written explanation 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.

Lock Out – HIP Plus members who fail to make timely POWER Account Contributions and have an income greater than 100% Federal Poverty Level (FPL) are subject to a six-month lockout period. They will lose HIP coverage and cannot reapply for at least six months unless they meet a lockout exemption or otherwise eligible by the State.

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.

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
PAC	POWER Account Contributions
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 - ဘာသာစကားဆင်ရာအကူအညီဝန်ဆောင်မှု များအား သင်အတွက် အခမဲ့ ရရနိုင်ပါသည်။ 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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CareSource
Health Care with Heart

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