CareSource®

2022 | Member Handbook

West Virgina

A Guide to Your Health Care Benefits

Health Insurance Marketplace

CareSource is a Qualified Health Plan issuer in the Health Insurance Marketplace.

CONTENTS

Welcome!

Thank you for being a CareSource member! We are glad to have you as a member of our health plan. At CareSource, we focus more on people than profits. Our marketplace health plans continue our long history of making health care coverage easy to understand and access. It's health care with heart!

Please review this handbook. It will help you better understand your benefits and coverage, and how to get the most out of your CareSource plan. In addition, please be sure to review your Schedule of Benefits (SB) and Evidence of Coverage (EOC). Your SB and EOC contain additional detailed information about your plan. Please read the entire SB and EOC and use them often as a reference for your covered services.

The information provided in this Member Handbook is meant to serve as an informative and quick reference guide. If there is any conflict between this Member Handbook and your Evidence of Coverage, the Evidence of Coverage shall control. If a specific situation or question arises regarding your rights and benefits under your plan, please reference your Evidence of Coverage. In addition, your Evidence of Coverage and this Handbook can be found on our website at **CareSource.com/marketplace**.

Member Services

You may also contact CareSource Member Services if you have questions about your plan, or to get more information about your rights and benefits under the plan. The Member Services phone number and TTY are in the footer at the bottom of each page of this handbook, and on the back of your CareSource ID card. Member Services is open Monday through Friday, from 7 a.m. to 7 p.m. Eastern Standard Time (EST) to take your call.

If you or someone you're helping have questions about CareSource, you have the right to get help and information in your language at no cost. Please call the Member Services number on your CareSource ID card for more information.

Spanish

Si usted o alguien a quien ayuda tienen preguntas sobre CareSource, tiene derecho a recibir esta información y ayuda en su propio idioma sin costo. Para hablar con un intérprete. Por favor,
llame al número de Servicios para Afiliados que figura en su tarjeta de identificación.

Arabic

إذا كان لديك، أو لدى أي شخص تساعده، أية استفسارات بخصوص فيحق لك الحصول على مساعدة ومعلومات مجاناً وباللغة التي ،CareSource تتحدث بها. للتحدث إلى أحد المترجمين الفوريين، رجى الاتصال على رقم خدمة الأعضاء الموجود على بطاقة تعريف العضو الخاصة بك.

Chinese

如果您或者您在帮助的人对 CareSource 存有疑问，您有权免费获得以您的语言提供的帮助和信息。
如果您需要与一位翻译交谈，请拨打您的会员 ID 卡上的会员服务电话号码。

Interpreter Services

If you or a member of your family has a primary language that is not English, call us. We offer interpreters for members who need assistance communicating with us. By calling the Member Services department at **1-855-202-0622** you can speak with a Member Services representative through an interpreter.

We make it easy to stay in touch with CareSource. Let us know when you have questions or need an interpreter. We are here to help.

TTY/TDD for the Hearing Impaired

Call 1-800-982-8771 or 711 if you are hearing impaired and have any questions, whether they are about your plan benefits and services or about your health and care.

Translation and Alternate Format Materials

You can request your plan documents and other print communication to be translated into the language of your choice. You can also request other formats, such as large print, braille or audio formats. Call Member Services to request a translation or alternate format material.

IMPORTANT NEXT STEPS

You've enrolled in your 2022 plan. Now what? Follow the steps below to get started with your new plan, and to review any changes from 2021, if you have re-enrolled with us.

1

Your Member ID Card

- Look for your ID card in the mail.
  - You will get your member ID card in a separate mailing.
  - You can also access your member ID card from your My CareSource® account, or view a digital copy of it on the CareSource mobile app.
  - Get more information about your ID card in the Getting Started section of this handbook.

2

Create Your Online My CareSource® Account or Update Your Existing Account

- Get quick and easy access to your plan and account information, as well as health and wellness information through **MyCareSource.com** and the mobile app.
- Go to **MyCareSource.com**. Then select ***Sign Up*** to create an account or ***Login*** to update your existing account.
  - If you have a new member ID number, you will need to update your account with your new plan information.
- Download our CareSource mobile app to stay connected on the go.

3

Learn About Your Benefits and Services

- Read about your covered benefits and services in the *Your Benefits* section of this handbook.
- You can also find information about your covered benefits and services online at: **CareSource.com/marketplace** and in your My CareSource account.

4

Learn About Special Programs Like Disease Management, Tobacco Cessation, Care Coordination and More

- In the *Member Exclusive Programs* section of this handbook. You can also call us for more information at 1-833-230-2011, Monday through Friday from 7 a.m. to 6 p.m. Eastern Standard Time.

5

Choose a Network Primary Care Physician (PCP)

- **FIND**: Use our ***Find a Doctor*** tool to locate the right doctor for you.
- **TELL US** your choice of PCP through your My CareSource account. Use the Choose Provider option and tell us your PCP's name. This isn't required, but helps ensure the right cost share amount is charged for each visit.
- **VISIT**: Make an appointment with your choice of PCP. It's important to have regular checkups, even when you are not sick.

6

Complete your Health Needs Assessment through MyHealth

- In your My CareSource account, select ***MyHealth***, then look for your Health Needs Assessment (HNA) under Assessments. Complete the survey to get a personal health score and a plan with tips for becoming or staying healthy!

YOU HAVE QUESTIONS.

We have answers!

Many questions you may have are pretty common among all of our members. This handbook should answer most of them. Below are some of the more frequently asked questions that you may have.

How do I get a replacement ID card?

If you've lost your CareSource ID card or need another copy, you can request one through your member portal account, MyCareSource.com, or call Member Services. Don't forget, you can use our mobile app to present your ID card digitally.

How do I find a network primary care provider (PCP)?

You can use our online Find A Doctor tool to find a PCP or specialist near you. You can also call Member Services, and a representative can help you find a PCP. When you find a PCP that you like, please let us know by entering his or her name in your My CareSource account.

Where can I find my plan documents?

Your plan documents are mailed to you when you enroll. You can also find your plan documents in your member portal account at **MyCareSource.com**. All plan documents are also posted on **CareSource.com/marketplace**. Use your plan name and benefit year to select the right documents.

Which plan document tells me my costs?

Your Schedule of Benefits, included with your annual member materials will show what your costs are for services.

How can I pay the bill for my monthly premium?

You can pay your bill in several convenient ways:

- By mail
- By phone
- Online
- Automatic monthly payments

See the invoice and payment section on pages 10 - 13 in this handbook for all the details.

How can I tell what my costs will be for a service or procedure before I get it?

- You can use our new Treatment Cost Navigator, available through your member portal account, **MyCareSource.com** to get an estimate and see what a provider may charge for a service.
- The Treatment Cost Navigator can also show you estimated costs charged for a service or procedure by multiple providers in your area.
- You can call Member Services for help figuring out your costs.
- You can ask your provider for an estimate up-front and what might influence their cost.

When to Update Your Information

Use CareSource's enrollment website **Enroll.CareSource.com** when you need to change or update your household information, such as:

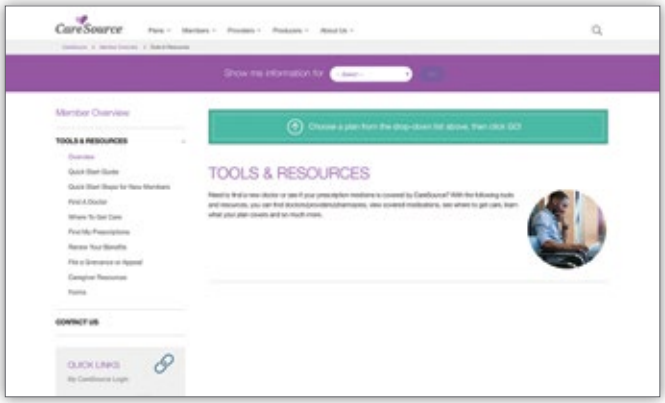
- When you move
- If you or someone in your household has a change in income
- If you adopt or have a child
- To permanently change your address or contact information

Our enrollment website provides an easy, no-hassle way to let the Marketplace know when you have changes to report. You can also call the Marketplace directly at 1-800-318-2596 (TTY: 855-889-4325) or go to Healthcare.gov*.

**Healthcare.gov and the Marketplace are products of the Centers for Medicaid and Medicare, and are not related to CareSource.*

DIGITAL TOOLS

Our suite of digital tools is designed to make it easy for you to get the information you want, when you want it.

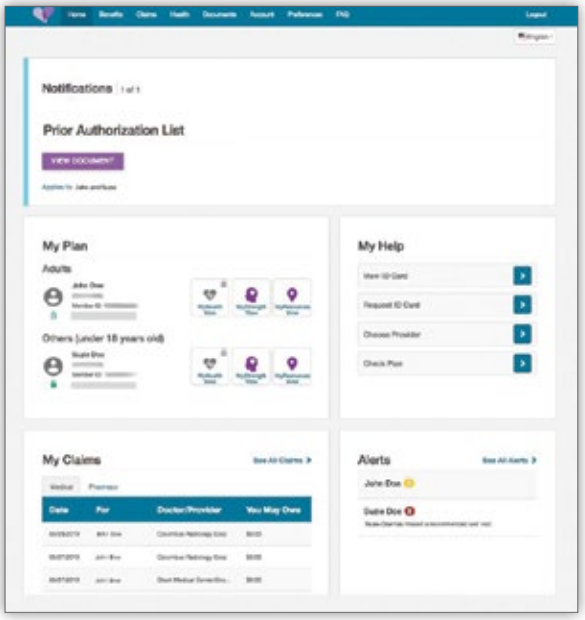


CareSource Website

CareSource.com/marketplace: Our website gives you general information about plans, pharmacy benefits, member-exclusive programs, and how to find network providers. It even has educational materials and videos. Our website is easier and faster than ever to use. We are always updating the information available to you, so visit often when you have questions about your health or your health care plan.

My CareSource Member Portal

Your personalized plan information and documents are available through your My CareSource member portal account. **MyCareSource.com** is your secure, personal CareSource account. It holds your Marketplace plan documents, cost information, claims, explanations of benefits, invoices, and more. If you've had a My CareSource account in the past, be sure to update it with your new Member ID number.

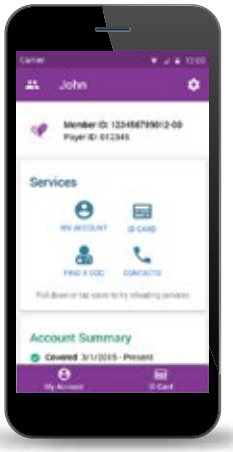


The My CareSource Account Home Screen

It is your **personal portal** to our online tools like **MyHealth, myStrength and MyResources**, to help you get additional support for your physical and emotional health, and find community resources. You can check your rewards (you're automatically enrolled in our Rewards program) and redeem them for gift cards.

Your My CareSource account gives you access to our new **Treatment Cost Navigator**. You can get an estimated cost for most services and procedures with multiple local providers, based on your deductible and costs.

Use your My CareSource account to get paperless invoices, explanations of benefits and more! Go to the **Preferences** page to set your preference for email and text. We will email or text you a notice when documents are available in your account. We can't email you notices for everything, but when we can, we will be happy to!



CareSource Mobile App

The CareSource Mobile App contains all your personalized information at your fingertips. The new **Message Center** will let you know if you are due for a screening test, a doctor visit, prescription refill, or when documents are available for you to review. Get one-touch access to your digital ID card, Find A Doctor and CareSource24®. Access telehealth 24 hours a day. Our app makes using your CareSource benefits easy and convenient.

GETTING STARTED

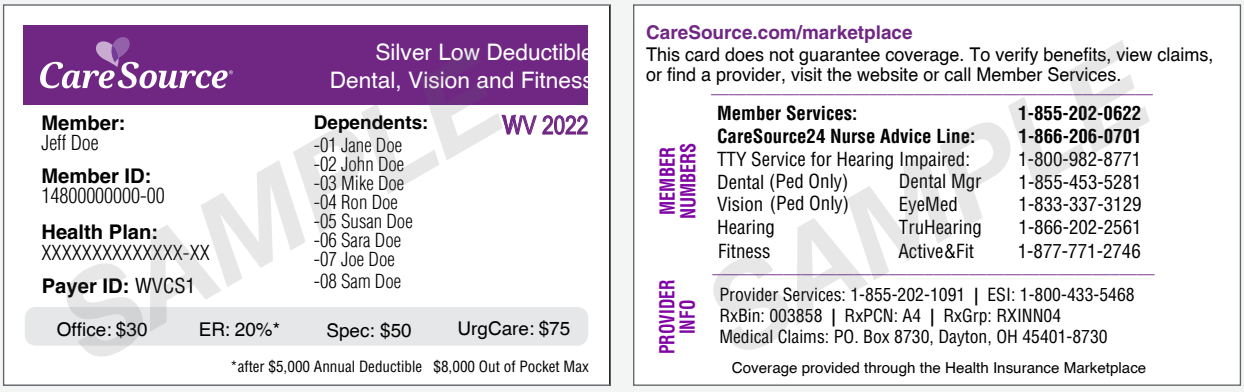
Information you need to know.

ID Cards

You will receive your CareSource ID cards in a separate mailing. They are also available on your My CareSource account and the CareSource mobile app. Your ID card lists each member of your family who has health insurance coverage under the Plan. Be sure to show your card each time you go to the doctor, hospital, urgent care center and pharmacy.

ID Cards show additional important contact information, including our 24/7 Nurse Advice Line, and Benefits Manager contact information, for your Vision, Dental, Hearing and Fitness benefits, as appropriate to your plan.

NOTE: You should always have your ID card ready when you call Member Services or any of the Member Benefits contact numbers. The member ID number listed on your card will help us serve you faster.



Additional/Replacement ID Cards

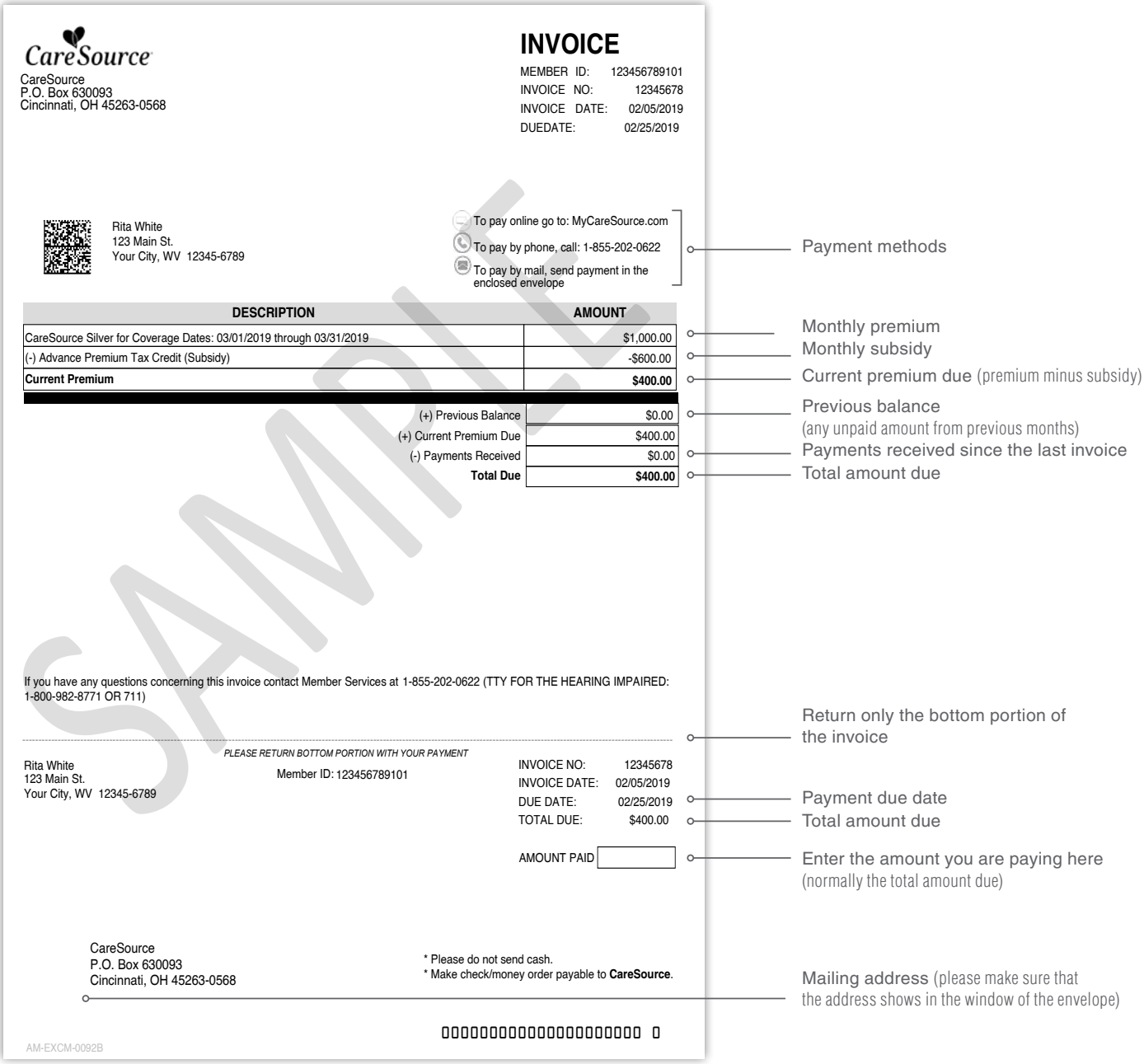
If you need additional ID cards or you lose your ID card, you may print it from your My CareSource account. You can also view a digital copy on the CareSource mobile app. You can request a replacement ID card through your My CareSource account, or by calling Member Services and telling our automated attendant that you need a replacement ID card.

Your CareSource Invoice

The payment you provide to CareSource for your health insurance coverage is called a premium. You will receive a monthly invoice from CareSource for the premium amount due for the upcoming month.

NEW: You can now opt to receive a notice via email or text that your invoice is ready to view on your My CareSource account instead of receiving a paper invoice in the mail. Go to your My CareSource account and click ***Preferences*** to update your email and text information.

Your monthly invoice will look something like this:



CareSource

CareSource
P.O. Box 630093
Cincinnati, OH 45263-0568

INVOICE

MEMBER ID: 123456789101
INVOICE NO: 12345678
INVOICE DATE: 02/05/2019
DUEDATE: 02/25/2019

Rita White
123 Main St.
Your City, WV 12345-6789

To pay online go to: MyCareSource.com
To pay by phone, call: 1-855-202-0622
To pay by mail, send payment in the enclosed envelope

Payment methods

DESCRIPTION	AMOUNT
CareSource Silver for Coverage Dates: 03/01/2019 through 03/31/2019	$1,000.00
(-) Advance Premium Tax Credit (Subsidy)	-$600.00
Current Premium	**$400.00**

Monthly premium
Monthly subsidy
Current premium due (premium minus subsidy)

(+) Previous Balance	$0.00
(+) Current Premium Due	$400.00
(-) Payments Received	$0.00
Total Due	**$400.00**

Previous balance (any unpaid amount from previous months)
Payments received since the last invoice
Total amount due

If you have any questions concerning this invoice contact Member Services at 1-855-202-0622 (TTY FOR THE HEARING IMPAIRED: 1-800-982-8771 OR 711)

Return only the bottom portion of the invoice

PLEASE RETURN BOTTOM PORTION WITH YOUR PAYMENT

Rita White
123 Main St.
Your City, WV 12345-6789

Member ID: 123456789101

INVOICE NO: 12345678
INVOICE DATE: 02/05/2019
DUE DATE: 02/25/2019
TOTAL DUE: $400.00

Payment due date
Total amount due

AMOUNT PAID

Enter the amount you are paying here (normally the total amount due)

CareSource
P.O. Box 630093
Cincinnati, OH 45263-0568

* Please do not send cash.
* Make check/money order payable to **CareSource**.

Mailing address (please make sure that the address shows in the window of the envelope)

AM-EXCM-0092B

SAMPLE

How to Pay Your Premium

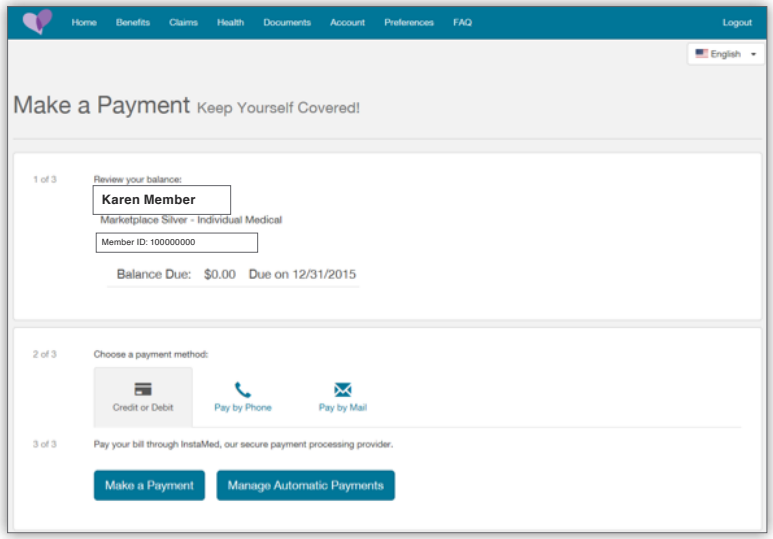
To pay your monthly premium to CareSource, you may:

Make an Express Payment online

- Go to **www.caresource.com/MPpay** and enter your member information to be taken directly to the payment screen.

Pay online through your My CareSource account

- Go to your My CareSource account and select ***Pay Bill***. You can choose ***Make a Payment*** for a one-time payment or ***Manage Automatic Payments*** to set up automatic monthly payments. Either option will take you to our secure, online payment processing vendor. Enter the requested information to make your payment or set up your automatic payment.



Pay by phone

- Call Member Services and tell our automated attendant that you would like to make a payment.
- Phone payments can be made through credit card, debit card or checking account.

Pay by mail

- Detach the bottom portion of your invoice and write in the amount of your check or money order.
- Include the bottom portion (remittance slip) of your invoice and your check or money order. Make sure that our address shows through the window of the envelope.
- Please include your member ID number on the memo portion of the check or money order.

Paying Your Premium On Time is Important

It is important to pay the total premium amount due by the due date! If we do not receive your premium payment by the due date on the invoice, then your account is considered past due, and your medical and pharmacy benefits are at risk.

If you receive an Advance Premium Tax Credit (APTC) to lower your payment:

Your grace period will be the three consecutive months after your missed premium payment. During this period we will:

- Continue to pay for covered services during the first month of the grace period;

- Hold on processing claims for covered services provided during the second and third months of the grace period. We may choose to pay these while reserving the right to recover any amounts paid during this period.
- Reject prescription drug claims during the second and third months of grace period.
- Notify network providers of the possibility for denied claims during the second and third months of the grace period.

Your grace period can come to an end in two ways:

1. You can pay the total premium amount due before the end of the grace period. We will then process all held claims. You should contact your pharmacy to reprocess prescription claims.
2. You can let the policy lapse and we will terminate your coverage back to the end of the first month of the grace period.

If you do not receive APTC, or you purchased your policy off the federal exchange:

Your grace period will be thirty-one (31) consecutive calendar days following the due date of your unpaid premium. During this period we will:

- Hold processing of claims for covered services provided during the grace period, or reserve the right to recover any amounts we may pay during this period;
- Reject prescription drug claims during the grace period;
- Notify network providers of the possibility for denied claims during the grace period.

Your grace period can come to an end in two ways.

1. You can pay the total premium amount due before the end of the grace period. We will then process all held claims. You should contact your pharmacy to reprocess any held prescription claims.
2. You can let the policy lapse and we will terminate your coverage back to the end of the last month paid.

For all members:

If you apply for new coverage through a special enrollment, or during open enrollment next year, payment for any past due premiums from the previous 12 months and the premium for the first month of new coverage must be paid in full by the due date to activate your new coverage.

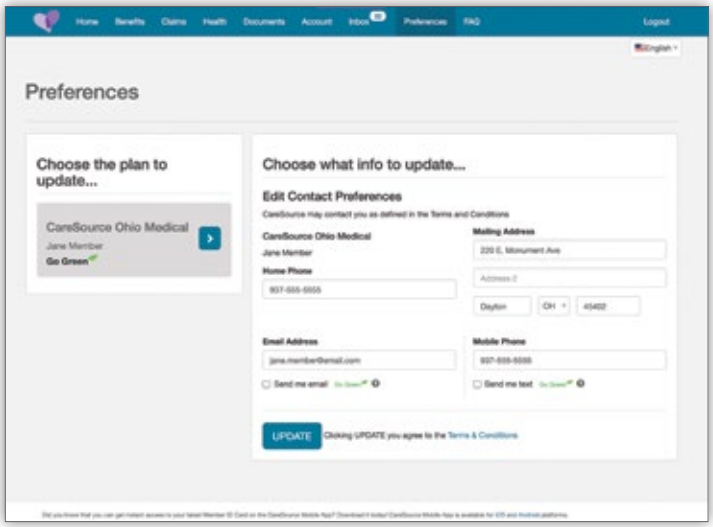
For more information on what will happen if you do not pay your premium payments on time, please refer to Section 3: *How the Plan Works* in your Evidence of Coverage.

Check your Payments and Balance

You can see when your last payment was posted by clicking ***Account*** at the top of your **MyCareSource.com** account screen. This will show your total amount due. Click the link on the right side of the screen that says ***View Account Activity***, and you will be able to see each payment and when it was received. You can also view and print invoices or request a copy of an invoice.

Communication from CareSource

In addition to your monthly invoice, CareSource may send you additional information to keep you up to date on your plan details and benefits available to all members.



Some of these communications may be about you or your family's specific health conditions, special programs offered to you, or care management opportunities. Some are just to keep you updated with the latest information about CareSource and your plan, like our quarterly newsletters. Your Explanation of Benefits is another regular communication you will get when you receive services. It helps you track your contributions toward your annual deductible and out-of-pocket maximum, as well as the services that have been billed by your providers.

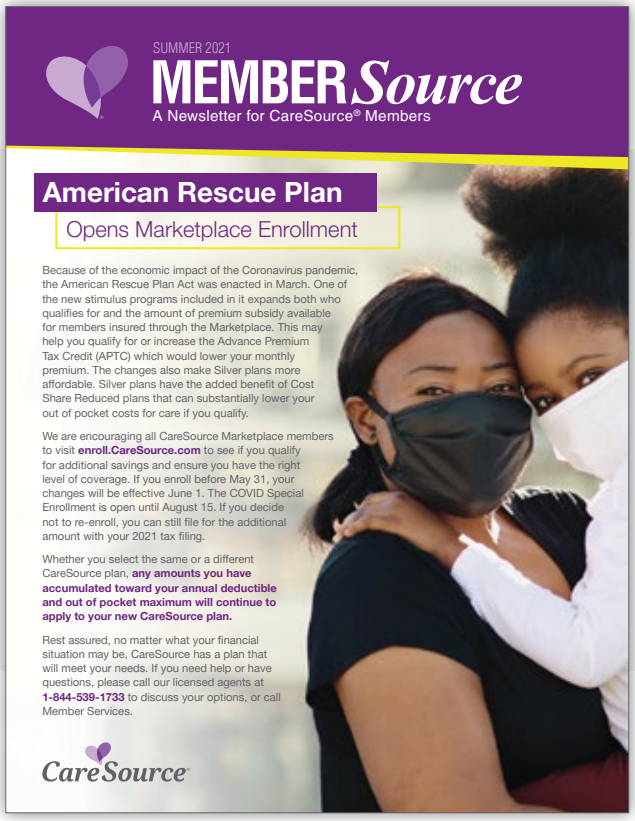
Go Green! You can choose to receive many communications through your My CareSource account, or through text or email. When you choose email or text, we will send you a notice that a document is available in your My CareSource account. Please remember that even if you choose email and/or text notifications, you will still receive mail from us as required by law.

Be sure to tell us your preferred method of contact through your My CareSource account so you get information from us in the format you prefer.

Member Newsletters

Our MemberSource newsletter is sent out quarterly, and is also available online at **CareSource.com/marketplace**, under the Education link.

The newsletter helps you take the fullest advantage of your plan benefits. It gives useful health and wellness information and keeps you up to date with what's happening at CareSource. You can view the most current issue, as well as past issues, at **CareSource.com/marketplace**, under ***Education***.



Explanation of Benefits

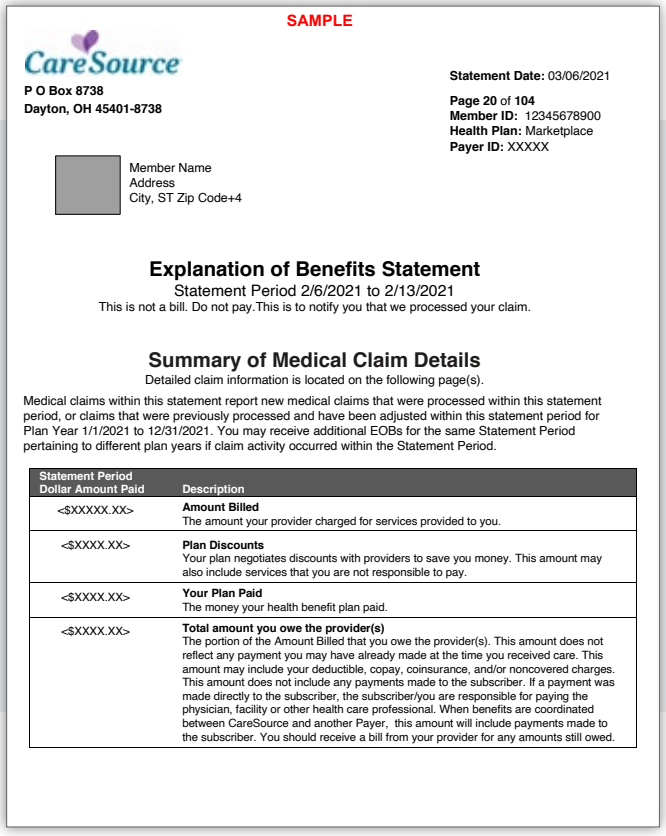
When you visit the doctor, or have other health care services, we will send you an Explanation of Benefits (EOB), or a notice by email or text that your EOB is available on your My CareSource account. The EOB is not a bill, it is a summary of the claim for services that your provider submitted and what CareSource paid to the provider.Your EOB will tell you:

- The member who got the service
- The provider who billed for the service
- The date the service was received
- A description of the service
- The amount CareSource paid for the service
- How much you owe or already paid for the service, if anything

If you do owe for a service, you will get a bill from the provider. We encourage you to save your EOB statements and pay only the amount listed as your responsibility. If you get a bill from a provider for more than the amount the EOB shows as your responsibility, or for services you did not receive, call Member Services at the number on the back of your ID card. Your EOBs are also posted in your My CareSource account, in the ***Documents*** tab.

It is important that you review your EOBs to be sure that you are being charged for the correct services and the correct amounts. Your review ensures that you are only being charged for services that you have received, and can help us and your provider prevent fraud.

Sample EOB



SAMPLE

CareSource

P O Box 8738
Dayton, OH 45401-8738

Statement Date: 03/06/2021

Page 20 of **104**
Member ID: 12345678900
Health Plan: Marketplace
Payer ID: XXXXX

Member Name
Address
City, ST Zip Code+4

Explanation of Benefits Statement
Statement Period 2/6/2021 to 2/13/2021
This is not a bill. Do not pay.This is to notify you that we processed your claim.

Summary of Medical Claim Details
Detailed claim information is located on the following page(s).

Medical claims within this statement report new medical claims that were processed within this statement period, or claims that were previously processed and have been adjusted within this statement period for Plan Year 1/1/2021 to 12/31/2021. You may receive additional EOBs for the same Statement Period pertaining to different plan years if claim activity occurred within the Statement Period.

Statement Period Dollar Amount Paid	Description
<$XXXX.XX>	**Amount Billed** The amount your provider charged for services provided to you.
<$XXXX.XX>	**Plan Discounts** Your plan negotiates discounts with providers to save you money. This amount may also include services that you are not responsible to pay.
<$XXXX.XX>	**Your Plan Paid** The money your health benefit plan paid.
<$XXXX.XX>	**Total amount you owe the provider(s)** The portion of the Amount Billed that you owe the provider(s). This amount does not reflect any payment you may have already made at the time you received care. This amount may include your deductible, copay, coinsurance, and/or noncovered charges. This amount does not include any payments made to the subscriber. If a payment was made directly to the subscriber, the subscriber/you are responsible for paying the physician, facility or other health care professional. When benefits are coordinated between CareSource and another Payer, this amount will include payments made to the subscriber. You should receive a bill from your provider for any amounts still owed.

SAMPLE

Medical Claim Details

Below you will find detail for each claim processed in this Statement Period. *Note* – Helpful Terms are defined following Claim Details. Also below is a list of Remark Codes to explain each claim denial reason.

Your Medical Claim Details

Provider: John Smith
Provider Type: In-Network Provider
Patient Account number: 5555
Dates of Service: 2/14/2021 – 2/18/2021
Claim number: 0006200VW200
<Adjusted>
Claim Paid On: 3/6/2021

Type of Service	Billed Charges	Plan Allowable	Discount Savings	CareSource Paid	Remark code(s)	Your Itemized Responsibility to Provider				The amount you owe
						Deduct.	Coinsurance	Copay	Exclusion Not Covered	
Physician Services	$104.00	$104.00	$0.00	$79.00	X94	$0.00	$0.00	$25.00	$0.00	$25.00
Physician Services	$200.00	$150.00	$50.00	$50.00	PDC	$0.00	$0.00	$100.00	$0.00	$100.00
Totals:	$304.00	$150.00	$50.00	$50.00		$0.00	$0.00	$125.00	$0.00	$125.00

What the Remark Codes Mean:

Code	Description
X94	Services performed require an authorization; claim disallowed.
PDC	Your network provider has agreed to the plan discount.

Your Prescription Claim Details

Fill Date	Prescription	Prescription cost	CareSource Paid	Your Itemized Responsibility to Provider			The amount you owe
				Copay/ Coinsurance	Deductible	Other	
2/18/2021	**Rx#:** 000006114100	$4.00	$0.00	$0.00	$4.00	$0.00	$4.00
Totals		$4.00	$0.00	$0.00	$4.00	$0.00	$4.00

Prescription claims included on this statement show prescription claims and total costs covered by CareSource for this statement period. Adjusted claims may be shown on this statement, and may show an amount that is different from what was listed on a previous statement. The cost of the prescription displayed is the negotiated rate for the pharmacy at the time of purchase, and does not take into account other reimbursements. Negotiated rates on prescription drugs may vary by pharmacy, quantity, strength and/or dosage of the drug.

In-Network	Doctors, hospitals, clinics and other providers that contract with your plan to provide services at a lower rate.
Out-of-Network	These expenses are covered only in the case of emergency care from an out-of-network provider, or urgent care services outside the service area, or other special circumstances.
Out-of-Pocket Maximum	The amount that you will pay each benefit year for covered services. For a complete definition, please refer to your Evidence of Coverage. When you have met your Annual Out of Pocket Maximum for a benefit year, your plan will pay 100% of eligible expenses for covered serviced through the end of that benefit year.
Plan's Limit	This is the specific deductible, coinsurance or out-of-pocket limit for your plan.
Remark Code(s)	A note that explains more about the costs, charges, and paid amounts for your visit. An explanation of remark codes is listed below each claim.
Service	The type of care you received. Different services can share the same label, like "Medical" or "Facility." This helps protect your privacy. Contact your provider or Customer Service for more details on a service.
The Amount You Owe	The amount you may ultimately pay the provider after any in-network discount and plan payments are applied. This does not reflect payments you have already made to the provider. For example, it could show a $25 copay that you paid at the time of the visit. That is why we say it is what your provider "may" bill you. By comparing EOBs with bills from your provider, you can make sure amounts are accurate and avoid overpaying.

Plan Features	Applies to the Annual Out-of-Pocket Maximum?
Copayments	Yes
Payments toward Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for Non-Covered Services	No
Optional Dental, Vision and Fitness Benefits	No

SAMPLE

Account Summary

Payment overview:

Deductible		Out-Of-Pocket Limit	
15% met		10% met	
15% In-Network	0% Out-Of-Network	10% In-Network	0% Out-Of-Network
$3,825 left to meet this deductible		$9,000 left to meet this limit	
Applied To-Date: $675		Applied To-Date: $1,000	
Plan's Deductible: $4,500		Plan's Limit: $10,000	

Summary of Deductible and Out of Pocket

Plan Year: 2021

Individual	Annual Limit	(-) Applied to Date				(=) Remaining Balance
		In Network Medical	Out of Network Medical	Prescriptions	Hearing	
Deductible	$4,500	$84				$3,875
Out of Pocket	$10,000	$204		$4		$9,000

Additional costs represent accumulated costs toward your deductible and out-of-pocket expenses. You will receive separate EOBs with claims details.

Non-Covered services represent the items or partial amounts that are not covered by your plan, including amounts from an out-of-network provider, which you may be responsible for paying.

SAMPLE

Annual Family Summary of Medical Expenses

Plan Year: 2021

Statement Summary of Family Medical Out-of-Pocket/Your Share Expenses, includes non-covered services.

Individual	Deductible	Copay	Coinsurance	Non-Covered Services	The Total Amount You Owe
David	$80.00	$100.00	$0.00	$136.88	$316.88
Marie	$25.00	$20.00	$0.00	$00.00	$45.00

Additional costs represent accumulated costs toward your deductible and out-of-pocket expenses. You will receive separate EOBs with claims details.

Non-Covered Services represent the items or partial amounts that are not covered by your plan, including amounts from an out-of-network provider, which you may be responsible for paying.

Your claim totals may differ from the detail above because the claim totals reported are for this statement period only.

HELPFUL TERMS

NOTE: We provide these definitions to help you understand important terms. Refer to your Evidence of Coverage and Schedule of Benefits for full details. In the event of any inconsistency between these definitions, the Evidence of Coverage and Schedule of Benefits shall govern.

Allowed Amount	The reduced rate CareSource negotiated with in-network providers for covered services. This is one of the reasons in-network care saves you money. For example, a doctor may charge $150 for a visit — but CareSource negotiated an allowed amount of $100. Thus, you save $50 as a plan member.
Appeal	A request that your health insurer review a decision that denies a benefit or payment (either in whole or in part).
Billed Charges	The amount your provider billed CareSource for the services you received.
CareSource Paid	The amount CareSource paid for services you received. Please note that this amount may be $0 if you receive services that go towards your deductible and your deductible has not been met or if your copay is equal to or more than the allowed amount. As a CareSource member, you receive discounts by using providers that are in-network.
Coinsurance	The percentage of a health care bill that you pay for certain covered services. When services have a coinsurance amount, you pay the Provider that amount, usually at the time of service.
Copayment	A fixed dollar amount that you pay for certain covered services, usually at the time of service. This amount, also called a copay, is a portion of the full billed amount.
Covered Services	Refer to your Evidence of Coverage for details on which health care services are covered by your plan.
Deductible	The amount you pay for covered services before the health plan starts to pay. Some benefits, such as preventive health services, are covered by the plan regardless of deductible. Please refer to your Evidence of Coverage and Schedule of Benefits for more detailed information.
Discount Savings	The total amount you saved from in-network discounts and plan payments.
Exclusion / Not Covered	This can include non-covered services or out-of-network costs above the allowed amount and services that did not have prior review (approval) as required.
Family Deductible	Once the sum of all family member payments meets the family deductible, each member begins to pay the copay or coinsurance amount.

UNDERSTANDING YOUR COSTS

Understanding cost for care doesn't have to be hard. We are here to help you whenever you have questions. We've changed a few things this year to help you better understand your out-of-pocket costs for care. Below is a brief explanation some terms used when talking about your costs, and some of the ways you can get the information you need about your cost of care. These terms are explained in detail in the *Glossary* section of this handbook.

Cost Shares

These are the amounts that are assigned to different services, and dictate how you and CareSource share the cost of your care. Cost shares are calculated as either a copay or coinsurance, depending on your plan and the service you receive. Within your plan, your costs can vary based on where you get care, as well as the type of provider you use. Some services, such as preventive care, are provided to you at no charge. That means that CareSource pays the full cost of these services.

Billed Amount

This is the amount that your provider charges for services. CareSource negotiates rates with a network of providers in order to keep costs low and ensure that you get high quality and respect for your rights as a member. If you use an out of network provider, it can result in services not being covered or higher costs for both you and us, because we don't have a contract with them.

Accumulated Amounts

Certain services are charged against your deductible before we contribute, and the majority of services accumulate toward your deductible and Maximum Out-of-pocket (MOOP) expenses. As you satisfy your deductible and MOOP, your cost for services may change, generally going down. The amounts you accumulate toward your deductible and MOOP are reflective of your out-of-pocket costs.

Cost Examples:

Below are two illustrations of how your costs are figured. One shows a typical emergency room visit. The other shows the costs for managing an ongoing health condition.

Example

Bob goes to the ER

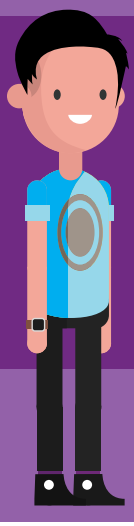
ER Costs		CareSource Coverage	
$5,000 facility charges	**$3,000** professional charges	**$6,500** deductible	**$250** copay after deductible for Emergency Room care

Bob pays $6,750 (facility and part of professional charges satisfy deductible, $250 copay on remaining charges.) If Bob has met his deductible, he would pay $250 for the ER copay.

Example

Managing Joe's Type 2 Diabetes

(a year of routine in-house care of a well-controlled condition)



$5,700 The Plan's overall deductable	**$50** Specialist copayment	**$450** Hospital (facility) copayment	**20%** Other coinsurance

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education.)*
Diagnostics tests *(blood work)*
Prescription drugs
Durable medical equipment (*glucose meter)*

Total EXAMPLE cost **$5,600**

In this example Joe would pay:

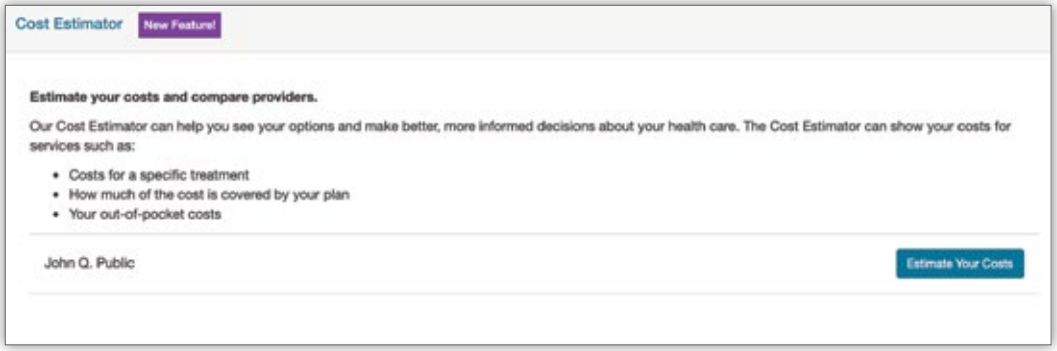
Cost sharing		*What isn't covered*	
Deductibles	$4,000	Limits or exclusions	$20
Copayments	$400		
Coinsurance	$0		

The total Joe would pay is **$4,420**

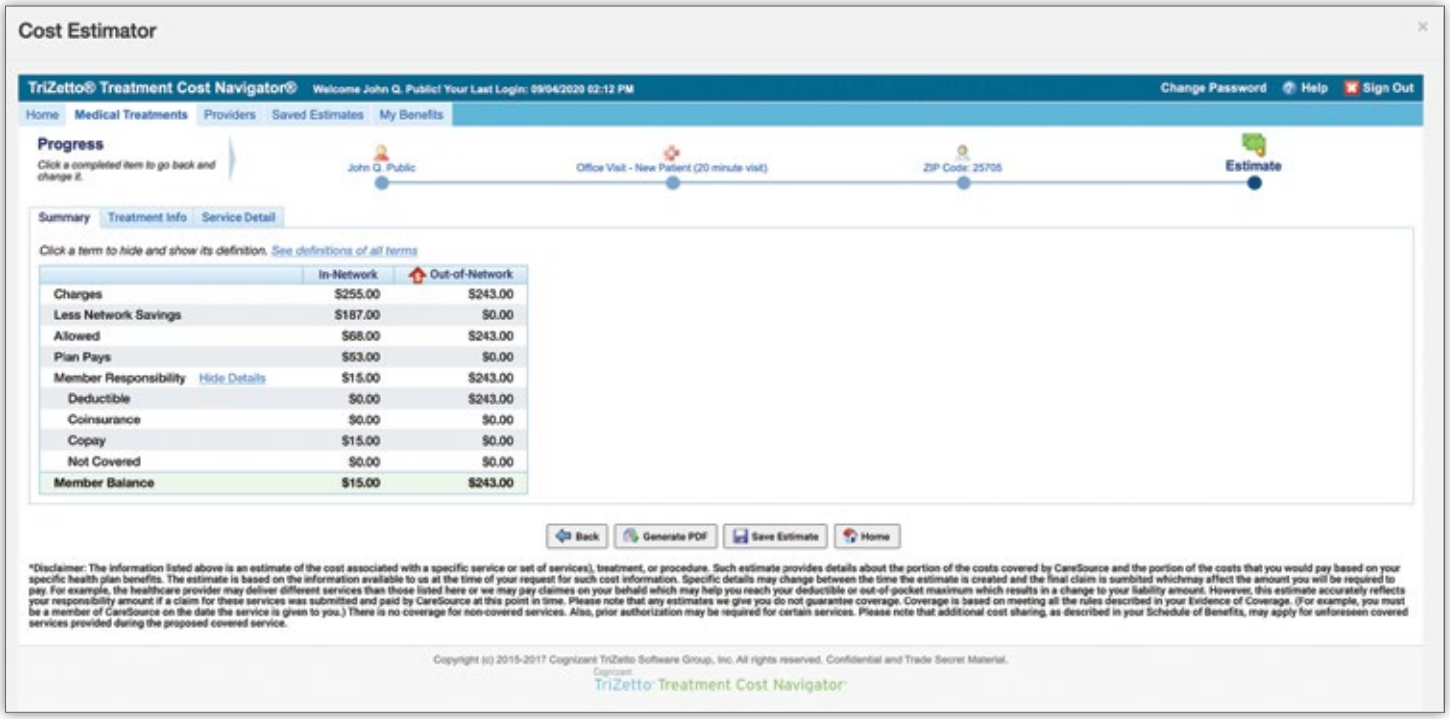
New Cost Estimator Tool!

Now you can get an estimate for the cost of many procedures and services **BEFORE** you receive them! Get your out of pocket costs and even shop for a facility or provider for the service. CareSource is pleased to give you more control and information about your costs using the new Treatment Cost Navigator.

To get started, log in to your My CareSource account, and click the **Benefits** tab. Follow the prompts for the Cost Estimator.



Follow the prompts to select the member and get started with the Treatment Cost Navigator. Enter the type of treatment or service needed and your location. If available, you can compare in-network providers for location and cost. You will see estimates for the cost of the service or procedure, how much your plan will pay, and what your out of pocket costs may be. If a prior authorization is needed, it will be highlighted at the top of the screen, as shown in the example below.



If you need help or more information, please call Member Services.

Tips to Lower Your Cost For Care

We want you to get the most out of your health care coverage. Here are a few easy ways to get the best use of your health care dollars:

Call the CareSource24® Nurse Advice Line to ensure you are going to the right place for care, such as seeing your PCP instead of going to the emergency room (ER). Not only are your plan's cost shares higher in the ER, but the amount billed by the provider will also be higher.

Make sure you are using network providers. Use the Find A Doctor tool to locate a provider near you. Go to **FindADoctor.CareSource.com**.

See your PCP more often and take advantage of free preventive care. Seeing your doctor regularly can help you better manage health issues, which can reduce your overall cost. Much like maintenance on a car, it will cost more if your brakes go out and you crash instead of getting them checked and serviced routinely. Visiting your doctor also allows you to plan for medical procedures.

Shop around for specialty services. Many of us cut coupons, shop for deals, and wait for sales. Applying those skills to your health care can go a long way toward saving you money. When you have the opportunity to plan ahead for your health care needs, you can shop to find the best provider at the best price for you. Before you receive a service, many providers can give you an idea of their cost and what you would pay.

Use a Health Savings Account (HSA). For members on our HSA Eligible plans, you are able to participate in an HSA, which can lower your cost for care. An HSA is a savings account for your health care. You can fund it with pretax contributions, which lowers how much tax you pay. Additionally, the money stays with you in your HSA and can stay with you wherever you go.

WHERE AND HOW TO GET CARE

Where to Get Care

You have options for care.

If you aren't sure where to go, call the CareSource24® Nurse Advice Line. Nurses are available to speak with you 24/7/365. The number is on the back of this newsletter, and on your CareSource member ID card.

Primary Care Provider (PCP)

Usually open during regular business hours. Appointment needed. For routine care, common illnesses and advice. May also offer telehealth. Contact your PCP's office to find out. Visit your doctor the most often!

Telehealth & RelyMD®

Convenient access to a doctor by phone or computer, from wherever you are. Your PCP may offer telehealth. Contact their office to find out. If your PCP is not available, call RelyMD at **1-855-879-4332** or visit **patient.relymd.app**.

Urgent Care

Usually open seven days a week with evening and weekend hours. When your PCP is not available. Your condition or injury can't wait. For common illnesses, x-rays, deep cuts, etc.

Hospital Emergency Room

Open 24 Hours a day, 365 days a year. When you are very sick or need immediate help. For life-threatening situations such as chest pain or a head injury.

Primary Care Provider

Your main source of care should be your Primary Care Provider (PCP), also known as a doctor, a primary care physician, a physician, a health care provider, or just provider. Your PCP will get to know you, and can coordinate any additional or extra care you may need, such as testing, or physician specialist referrals. Your PCP should be familiar with your CareSource plan and what is covered, but it is always a good idea to check with your doctor or with CareSource to ensure a test, specialist or treatment is covered.

Going to the same PCP each time you need care will help your PCP get to know you and your needs. The more familiar your PCP is with you and your medical history, the better your PCP will be able to treat you. You can see any in-network PCP or provider that you like.

Telling us your PCP in your My CareSource account or the CareSource mobile app will let us know who your PCP is, and ensure that we are applying the right cost share amount to your claims. It will also allow us to communicate more effectively with your PCP about your care and important health alerts. You do not have to notify us if you change your PCP, and you can change as often as you like. If you want to change the PCP you have on record with us, it is easiest to change it through your My CareSource account.

To locate a PCP, specialist or other in-network provider, use our ***Find A Doctor*** tool available through ***CareSource.com/marketplace*** or on the CareSource mobile app. You may also call Member Services and they will help you locate a provider.

CareSource24 Nurse Advice Line

Our CareSource24 Nurse Advice Line is available 24 hours a day, 365 days a year. If you are injured or sick, call the CareSource24 number on the back of your ID card. A Registered Nurse will ask you questions and advise you: if care is needed, what kind of care, when it is needed and who should provide it.* If the nurse refers you to Rely MD for a telehealth visit, you can be connected without making another phone call. CareSource24 services are available at no cost to you.

When you call CareSource24, a nurse can help you*:

- Discuss care advice for an injury or illness
- Decide when to visit a health care provider, urgent care, or emergency room
- Understand a health condition
- Make a list of questions before visiting a health care provider
- Learn about medication side effects, generic substitutes, and drug-to-drug interactions

Call CareSource24 at 1-866-206-0701

** CareSource24 Registered Nurses cannot diagnose or treat conditions. They can provide care advice, and answer your health related questions. In the case of a true medical emergency, always call 911 first.*

Telehealth Medicine

You can access health care virtually with telehealth. Telehealth can be a significant value to you by potentially increasing the speed of scheduling a visit and being seen, reducing time off work, reducing exposure to other patients, and more. While not all services are right for telehealth, many are, and more providers are supporting them than ever before.

Your PCP or other local provider may offer telehealth visits. Many reasons for a PCP visit can be taken care of over the phone or computer, such as medication check-ins, rashes, allergies, sinus issues, and more. Check with your provider to see if telehealth visits are offered, and get the details of how to schedule and have a virtual visit or a visit over the phone.

Urgent Care Clinics

Urgent care clinics should be used for situations that require prompt attention, when you cannot get in to see your Primary Care Physician (PCP) quickly enough. You should also consider going to an urgent care clinic when you require a higher level of care than your PCP can provide. If you aren't sure where to go for care, call our 24 hour Nurse Advice Line, CareSource24. The number is on the back of your ID card.

To find the nearest urgent care clinic, use our ***Find a Doctor*** online tool and look under "Clinic" for Type, then select Urgent Care/After Hours for the Specialty. You can also call our Member Services department, or CareSource24 and they can help you find an urgent care clinic near you. You can also call an urgent care clinic near you directly and ask them if they accept CareSource Marketplace plans.

Hospital Emergency Room

A hospital emergency room visit should be reserved only for true emergencies. They are typically the most expensive course of action for you. If your issue is not a true emergency, you may have to wait an extended time to get attention, and your claim may not be covered.

Some examples of when emergency services are needed include:

- Drug overdose
- Loss of consciousness
- Major burns
- Miscarriage/pregnancy with vaginal bleeding
- Psychosis
- Rape
- Severe chest pain
- Severe vomiting
- Seizures/convulsions
- Shortness of breath
- Uncontrolled bleeding

You do not have to contact CareSource for an OK before you get emergency services.

If you have an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your PCP or the CareSource24 Nurse Advice Line. Either can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a CareSource member and show your ID card.
- If the provider treating you for an emergency takes care of your emergency but thinks you need other medical care to treat the problem that caused your emergency, then you or the provider must call CareSource.
- If you are able, call your PCP as soon as you can to let him or her know that you had a medical emergency, or have someone call for you. Call your PCP as soon as you can after the emergency to schedule any follow-up services you may need.

- If the hospital has you stay (admits you to a room in the hospital), please make sure that CareSource is called within 24 hours.

Use Network Providers

Generally, you must receive care from a CareSource network provider. A network provider is a doctor, pharmacy, hospital, clinic or other health care provider contracted with CareSource to provide health care services to our members.

You can find network providers listed through our mobile app, on our ***Find a Doctor*** tool at **CareSource.com/marketplace** or you can request a printed Provider Directory for a listing of providers near you. You may also call Member Services and a representative will help find a network provider near you.

In order to have your health care services covered by CareSource, you must get them from a network provider with a few notable exceptions:

- A non-network provider renders emergency health services to you;
- You receive emergency or urgent care while you are temporarily outside the service area;
- There is a specific situation involving the continuity of your health care;
- You get health care services from a non-network provider (such as an anesthesiologist or radiologist) while you are in a hospital or other facility that is a network provider,; or
- The Health Care Services you need are covered services under the plan and not available from a network provider or facility. In this case, you, your PCP or other network provider must get our prior authorization.

If you receive emergency care from a non-network provider you will not be responsible for paying any more than you would have if you received care from a network provider.

These exceptions are related to the new “No Surprises” Act. You can read the full notice of your rights and protections under this act in the Appendix of this handbook.

Please be sure to refer to Section 3: *How the Plan Works* of your Evidence of Coverage for details and exceptions to using a network provider.

Finding a Doctor

Use our ***Find A Doctor*** online tool to search for primary care and specialists of all types. You can search for providers by specialty, within a certain area, by gender, by accessibility, and languages spoken. The ***Find A Doctor*** tool and our provider directory also list network providers by specialty, as well as hospitals, clinics and outpatient facilities.

A fixed link to the Find A Doctor tool is located on the top right of the **CareSource.com** website, or you can type **findadoctor.caresource.com** to go directly to the tool.

Visits to dentists and behavioral health specialists, like visits to other specialists, do not require a referral. However, you may want to work with your primary care provider (PCP) in coordinating your care.

If you would like a printed provider directory, please contact Member Services.

Current Treatment Plans and Continuity of Care

If you enroll in a CareSource plan and already have treatment or care planned, and the provider is not in our network, please contact us before you get that service. CareSource will be able to confirm if you qualify for a "Continuity of Care" exception to see an out of network provider. Note that these exceptions are limited to specific situations and will only be approved for certain timeframes. Except for emergencies, services you get from out of network providers without prior approval will not be covered. See the prior authorization explanation in the Benefits section of this handbook for more information about getting approval from us.

When you are Outside of our Service Area

You may get sick or hurt while traveling outside of our service area. Our service area is generally considered certain counties within the state where you purchased your policy. You can see the service area for each state online at **CareSource.com**. Select ***Plans*** from the main menu at the top of the page, then ***Marketplace*** and then your state.

If you have an emergency or need attention while outside our service area, and you are within the United States, you can get medically necessary covered services for urgent or emergency care from a provider that is not in our network.

Before seeking urgent or emergency care, we encourage you to call your PCP or CareSource24 for guidance, but this is not required. You should get urgent care from the nearest and most appropriate health care provider. Urgent and emergency care is covered both in and out of our service area.

If you receive urgent or emergency care from a provider who is not a network provider, they will most likely submit a claim to us using the information on your ID card. However, you may need to submit any bills you receive to CareSource, along with a claim form. We have included a claim form in the Appendix of this handbook. You can also get a member claim form online at **CareSource.com/marketplace**, on the ***Forms*** page under ***Tools and Resources***, or by calling Member Services.

As a reminder, you can use our telehealth provider, RelyMD. RelyMD is available 24 hours a day, 7 days a week, and all you need is a telephone or computer to get care. Telehealth is great for non-emergency situations where you don't need to go to the emergency room, but you need care soon. Learn more about RelyMD and how to use their service in the Where to Get Care section of this handbook.

YOUR BENEFITS

Covered Benefits At A Glance

Get the most out of your CareSource plan by understanding what benefits are available This is an overview of your benefits as a CareSource member. Put them to work for you! You can learn more about how to use these benefits in this handbook, at **CareSource.com/marketplace**, or by calling Member Services.

If an item on this list has an asterisk (*) after it, it means that a prior authorization may be needed before you can use this benefit. You can learn more about prior authorizations later in this section of the handbook, in your Evidence of Coverage, or by calling Member Services. Access the Prior Authorization List on **CareSource.com/marketplace**, on the ***Quick Links*** menu.

Health Care Visits

Birthing Centers

Community Behavioral Health Centers (CBHCs)

Convenience Care Clinics inside of stores like CVS®, Kroger® and Walmart®

Emergency Room (ER)

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC)

Hospital (Inpatient* and Outpatient)

Telehealth - virtual doctor visits over the phone or online including RelyMD®

Primary Care Providers (PCP) like Doctors, OB/GYNs, Physician Assistants and Nurse Practitioners

Skilled Nursing Facility* (SNF)

Specialists (e.g., Podiatrist, Neurologist and Oncologist.)

Urgent Care Center

Preventive and Early Detection Care/Screenings

Annual Well Visit (Physical Exam)

Autism Spectrum Disorder Screening

Blood Pressure Screening (Adults)

Breast Cancer Screening (Mammogram)

Cervical and Vaginal Cancer Screening (Pap smear)
Cholesterol Screening (Adults)

Colorectal Cancer Screening

Developmental Screening (Under age three)

Diabetes Screening

Disease Screening and Treatments (e.g., Hepatitis, HIV and STI/STD.)

Domestic/Interpersonal Violence Screening

Glaucoma Screening Immunizations (e.g., Flu, Pertussis and Hep B shots.) Lung Cancer Screening Prostate Cancer Screening Sports Physicals

Health Condition Management

Chemotherapy and Radiation*

Diabetes Education

Diabetes Screening

Diabetic Services and Supplies

Dialysis Treatment

Kidney Disease Services and Supplies

Pulmonary (Lung) Rehabilitation Services*

Health Condition Management

Chemotherapy and Radiation*

Diabetes Education

Diabetes Screening

Diabetic Services and Supplies

Dialysis Treatment

Kidney Disease Services and Supplies

Pulmonary (Lung) Rehabilitation Services*

Diagnostics

Blood Work/Lab Testing*

Scans (e.g., CT, MRI and PET*.)

X-Rays

Heart

Abdominal Aortic Aneurysm Screening

Cardiac (Heart) Rehabilitation Services*

Electrocardiogram* (ECG/EKG)

Heart Disease Risk Reduction Visit (Therapy for Heart Disease)

Heart Disease Testing

Behavioral Health

All Inpatient Services*

Electroconvulsive Therapy (ECT)

Family Psychotherapy*

Group Therapy

Individual Psychotherapy*

Intensive Outpatient Program (IOP) Services*

Medication Assisted Treatment (MAT)

Partial Hospitalization Program (PHP) Services*

Pharmacological Management

Psychiatric Diagnostic Evaluation

Psychiatric Residential Treatment* (PRTF)

Psychological Testing

Substance Use Disorder (SUD) Residential*

Transcranial Magnetic Stimulation* (TMS)

Dental

(All pediatric members and adults with Dental, Vision and Fitness plans)

Accidental Dental Services

Dental Exams and Cleanings

Dental X-Rays*

Dentures*

Fluoride Treatments (Pediatric Only)

Medically Necessary Orthodontics (Pediatric Only) *

Surgeries and Procedures* (Extractions, Restorations, etc.)

Transportation Services

Emergency (Ambulance, Air Flights, etc.)

Non-Emergency Transfers* (Non-Network to Network Facility, Hospital to Skilled Nursing Facility, etc.)

Pharmacy and Medications

Brand, Generic and Specialty* Drugs (Multiple Tiers)

Mail Order Drugs

Family Planning and Maternity Services

Birth Control and Contraceptive Supplies*

Breastfeeding Support, Supplies and Counseling

Breast Pumps

Folic Acid Supplements

Infertility Services (Diagnosis and Treatment)

Lactation Classes

Maternal Depression Screening

Newborn Screenings (Sickle Cell, PKU, etc.)

Parent Education

Prenatal and Postpartum Doctor and Home Visits

STD/STI Screenings and Treatment Sterilization*

Home Health Care*

Durable Medical Equipment *(DME – See Medical Supplies)*

Home Infusion Therapy*

Home Nursing Services* (e.g., Skilled Nursing and Private Duty.) (Private Duty not available to Georgia plans)

Physical, Occupational and Speech Therapy*

Vision/Eye Care

(All pediatric members and adults with Dental, Vision and Fitness plans)

Eye Exams (one comprehensive exam per year)

Glasses or Contacts (one per year; selection criteria applies)

Low Vision Aids (one per year)

Low Vision Evaluation (under 18 years and every five years)

Replacement Glasses or Contacts (one per year for damage only)

Other Care

ABA therapy* (Applied Behavioral Analysis)

Allergy Testing and Treatment

Bereavement Services

Bone Mass Measurements

Chiropractic Services*

Hearing Exam

Hearing Aids *(for KY only – all others eligible for a discount)*

Hospice Care*

Inhalation Therapy* (Asthma, Breathing, etc.)

Medical Nutrition Therapy*

Nutritional Counseling

Obesity/BMI Screening and Dietary Counseling

Occupational Therapy*

Pain Management*

Physical Therapy*

Podiatry (Foot) Services

Smoking/Tobacco Cessation (Counseling to quit smoking/tobacco use)

Speech Therapy*

Surgeries* (General, Reconstructive, etc.)

TMJ Services* (Jaw pain or problems with jaw movement)

Transplant Services*

Medical Supplies

Cochlear Implants*

Diabetic Supplies (Lancets, Test Strips and Monitors)

Durable Medical Equipment (DME) and Related Supplies* (e.g., Oxygen Tank, Wheelchair/Walkers and Wound Care.)

Nutritional Supplies*

Prosthetic Devices and Related Supplies*

Additional Programs, Services, and Rewards

Active&Fit® Program (Adults with Dental, Vision and Fitness plans)

Care Management

CareSource Mobile App

CareSource24® 24 Hour Nurse Advice Line

Disease Management

Fifth Third Express Banking®

Health and Wellness Education Programs

Health Savings Accounts through HSA Bank

Medication Therapy Management

MyHealth Online Tool

myStrengthSM Online Mental Health tool

**Prior authorization may be required.*
† Available only for certain Marketplace plans.

Contact your provider for further details on when a prior authorization is required. You can also review our prior authorization list at **CareSource.com/marketplace** in the Quick Links menu.

Please refer to your *Evidence of Coverage (EOC)* for more details and any limits that may apply.

Benefit Limitations

Several covered services have benefit limits of a maximum number of times that you can receive the service. This is usually stated in terms of visits or days. These limits can be found in your Schedule of Benefits and your Evidence of Coverage plan documents. Once these limits are exhausted, additional use of that service would no longer be a covered service, and you would be responsible for the full cost of the service.

Preventive Care

Preventive care means making regular visits to your Primary Care Provider (PCP), even when you do not feel sick. Routine checkups, tests and screenings can help your doctor find and treat problems early before they become serious. The list shown on the following page will give you an idea of some of the more common preventive care services and general ages recommended by industry experts.

Beyond your annual wellness check with your doctor being covered at no cost, many of the listed preventive care services are covered at no cost to you when received from in-network providers. Visit your PCP at least once a year to discuss what preventive screenings and tests are right for you. To learn more about the preventive care that is covered under your Marketplace plan, visit the Marketplace website at **www.healthcare.gov/coverage/preventive-care-benefits/**.

Are You Getting Your Preventive Care?

Screening and Counseling

Everyone 18+

- Blood pressure check
- Weight screening and counseling
- Depression screening and counseling
- Alcohol use screening and counseling
- Tobacco use screening and programs to quit smoking
- Diet counseling (If at a higher risk for chronic disease)
- Sexually transmitted infection (STI) prevention counseling

Age 50+

- Colorectal cancer screening (to age 75)

Age 55+

- Lung cancer screening for smokers or those who quit in the past 15 years (to age 80)

Vaccines

Everyone 18+

- Flu shot
- HPV vaccine (women to age 26, men 22 to 26 if at high risk)*
- Td/Tdap (tetanus) vaccine and boosters
- Chickenpox vaccine (if not immune)*
- MMR vaccine (if born after 1957)*
- Hepititis A vaccine (if at higher risk)
- Hepititis B vaccine (if at higher risk)
- Meningococcal vaccine (if at high risk)

Age 60+

- Shingles vaccine

Age 55+

- Pnemococcal vaccine

*Pregnant woman should not get the HPV, chickenpox, or MMR vaccines

Lab Tests

Everyone 18+

- HIV screeing (to age 65, beyond if high risk)
- Diabetes screening (if high blood pressure)
- Syphilis screening (if at higher risk)
- Hepatitis B screening (if at higher risk)
- Hepatitis C screening (if born 1945-1965 or at higher risk)

Age 35+

- Cholesterol screening for men

Age 45+

- Cholesterol screening for women (if at increased risk of heart disease

Just for Women

Everyone 18+

- Annual well-woman visit (to age 65)
- Contraception (except under certain plans with religious exemptions)
- Cervical cancer screenings (ages 21 to 65)
- Domestic or interpersonal violence and counseling
- Chlamydia and gonorrhea screening (if at higher risk)
- Breast cancer genetic testing and prevention counseling (if at higher risk)
- Additional preventive care for women who are pregnant or might become pregnant

Age 40+

- Breast cancer screening (mammograms)

Age 60+

- Bone density screening

**Availability of preventive services, including no cost share, depends on plan, market, and your characteristics.*

Staying Healthy

Your health is important. In addition to eating right and exercise, here are some ways that CareSource and your PCP can help you can maintain or improve your health:

- Establish a relationship with a Primary Care Provider.
- Make sure you and your family have regular checkups with your PCP and get the appropriate preventive services.
- If you have a chronic condition (such as asthma or diabetes), see your provider regularly. You also need to follow the treatment that your provider has given you. Make sure that you take any medications that are prescribed for your provider or pharmacist instructs.
- Remember, the CareSource24 Nurse Advice Line is available to help you. You can call the number on your member ID card anytime day or night, any day of the year.
- CareSource has programs that can help you maintain or improve your health. You can visit CareSource.com/marketplace, your member portal account at **MyCareSource.com**, or call Member Services for more information about programs that may be right for you.

Services that Require a Prior Authorization

What is a prior authorization?

A prior authorization is a CareSource approval for care and services before they are received by you. They are defined by us as out of the ordinary, and needing a utilization review to ensure that the care or service is medically necessary and appropriate for your situation.

Who is responsible for requesting a prior authorization?

Your doctor will request a prior authorization from us for services that need one. For example, some procedures and most inpatient hospital stays require a prior authorization.

If you are seeing a CareSource network provider, it is their responsibility to get a prior approval from us for your care when needed. If your provider does not get the prior authorization, you will not be held financially responsible for the cost of care you would normally pay.

If you see a non-network provider, your care may be covered under specific circumstances (like continuing care when you first enroll), but if your provider fails to get a prior authorization from us, you may be responsible for the total cost of your care.

What care and services require a prior authorization?

A list of the services that require prior authorization is available through your My CareSource account and on **CareSource.com**. Hover over ***Plans***, select ***Benefits and Services*** under ***Marketplace***. Pick your state, then ***Referrals and Prior Authorizations*** from the menu or from the ***Quick Links*** menu. You may also call Member Services and request a printed copy of the Prior Authorization List.

Many of your covered services do not need a prior authorization. You do not need a prior authorization to see your PCP or most in-network specialists. You do not need a prior authorization for lab work, X-rays or many outpatient services either, as long as the provider is in our network. Your provider will tell you when you need these, but you are responsible to ensure that you receive these types of care from a network provider.

Behavioral Health

Good health means more than just taking care of physical needs. It means addressing the health of mind, body and spirit. Behavioral health encompasses mental health and substance use disorders. It is an important part of your overall health. You can get mental health counseling or substance use help (for things like alcohol, illegal drugs, tobacco and prescription abuse) and your benefits are the same.

You have treatment and counseling options to help you through difficult times in your life. It's ok to ask for help. Our behavioral health services can help you cope with all kinds of issues. We can connect you to mental health or addiction services and help you find an experienced network provider.

You can also use our Find a Doctor search tool, call Member Services, or get a recommendation from your PCP to find providers and facilities near you.

Your CareSource24 Nurse Advice Line can help you if need help immediately. They can listen, and refer you to the appropriate help. You can use our online ***Find A Doctor*** tool to find a psychiatrist or psychologist in your area. You can also call member services for help finding a provider and making an appointment.

You can use our online tool, myStrength, to help you learn about ways to lower your stress, deal with difficult situations, and deal with grief. myStrength is available through your **MyCareSource.com** account.

You may also want to explore Care Management to help you coordinate your physical and mental or emotional care and help you manage your condition better. You can call Care Management at 833-230-2011 from 7 a.m. to 6 p.m. Monday through Friday, Eastern Standard Time.

Crisis and Support Numbers

If you have an emergency medical situation, such as a heart attack or broken bone, call 9-1-1 or go to the nearest emergency room.

- National Suicide Prevention Lifeline: 1-800-273-8255
- Crisis Text Line: Text 'HELLO' to 741741
- National Domestic Violence Hotline: 1-800-799-SAFE (7233) or text 'START' to 88788
- Substance Abuse and Mental Health Services Administration (SAMHSA) National Treatment Service Locator: 1-800-662-HELP (4357)

National Resources

- Substance Abuse and Mental Health Services Administration: **www.samhsa.gov/**
- National Alliance on Mental Illness: **www.nami.org/**
- National Institute of Mental Health: **www.nimh.nih.gov/**
- Mental Health.gov: **www.mentalhealth.gov/**
- Mental Health America: **www.mhanational.org/**
- Centers for Disease Control and Prevention: **www.cdc.gov/mentalhealth/**
- National Institute on Drug Abuse: **www.drugabuse.gov/**

Addiction and Substance Use Disorder

Almost everyone has been impacted by our growing national substance abuse problem. Either someone in our family or one of our friends has been affected. You may even wonder if you have a substance abuse issue. Substance abuse includes alcohol, tobacco, prescribed medication (like opioids or anxiety medication) or illegal drugs.

We believe in recovery. We believe that treatment works. And we can help you find treatment with an experienced provider. It's ok to ask for help, you don't have to face it alone. Whether it is you or someone you are close to, substance abuse can have a devastating effect on your family and friends.

What To Expect

Recognizing you need treatment takes courage and strength. And it's important that you don't try to do it alone. Treatment is more than addressing your addiction. It includes addressing your day-to-day challenges, such as medical needs, mental and social challenges, family history and more.

Treatment is different for everyone. It's not a one-size-fits all solution. A health care professional can help you determine which combination of support services will work best for you.

What Do Treatment Programs Do?

Detoxification

Detoxification, or detox, is the phase in which your body physically withdraws from drugs. It's good to go through this process at an inpatient treatment facility or through an outpatient program so you can be monitored by a health care professional.

Counseling and Behavioral Therapy

Therapy is a critical part to recovery. Recovery will be hard physically, mentally and emotionally, so having a professional support you through this journey is important. They will give you tools and techniques to help you stick to your treatment and they will address additional day-to-day challenges, such as mental and social challenges, family history and more.

Medication

Your doctor may prescribe medications that help you with withdrawal symptoms. Some common examples include buprenorphine/naloxone, Vivitrol, or methadone. Taking medication AND therapy can be a highly effective way to treat addiction.

Support Groups

Addiction can make you feel like you are alone. But many people battle addiction. Support groups allow you to connect with people who are on the same recovery journey. And more often than not, these people become your trusted friends for the long-haul.

Where Do I Start?

When you are ready for treatment it's important to start right away.

- Contact CareSource Member Services for assistance with finding a provider and scheduling an appointment.
- Call our Care Advocates through the dedicated addiction treatment phone number at **1-833-674-6437**.
- Access ***Find a Doctor*** on our website to find doctors who treat addiction in your area.
- Talk with your doctor about addiction.
- Contact your Care Manager with CareSource.

Accidental Dental Coverage

All members have coverage for dental benefits if they are in relation to an injury to the jaw or face from an accident. We will cover the initial dental work that you may need, including exams, x-rays, and restoration. There is a cost limit for dental coverage per accidental injury. Injury from chewing or biting is not considered accidental. Please review your Schedule of Benefits for the cost coverage for your plan. See Section 5 of your EOC for all the details.

Pediatric Dental Benefits

All children age 18 and under on CareSource marketplace plans have pediatric dental services. Benefits include:

- $0 cost share for diagnostic/preventive services, including two cleanings, two oral evaluations, and imaging services.
- Basic restorative services (fillings), subject to cost share.
- Major restorative services (extractions, root canals, dentures and crowns), subject to cost share.
- Medically necessary orthodontia (braces for certain medical conditions), subject to cost share.

See your Evidence of Coverage for a complete listing of your covered services, and your Schedule of Benefits for the cost shares associated.

Dental Services are provided through our partnership with DentaQuest, so make certain to use a DentaQuest provider. Dental care providers can be found using our Find a Doctor tool on CareSource.com. Search for “Dentistry” as the specialty to locate a provider near you, or call DentaQuest directly at 1-855-453-5281.

Pediatric Vision Benefits

All children age 18 and under on CareSource marketplace plans have pediatric vision services. Pediatric vision services are covered through our EyeMed partnership, allowing us to offer one of the largest nationwide network of providers. Benefits cover annual eye exams, glasses, contact lenses, and more. To find a provider, you can use our ***Find A Doctor tool***, or call EyeMed directly at 1-833-337-3129. When you schedule an appointment with a provider, tell them you have EyeMed insurance through CareSource and they will confirm your plan and benefits.

Learn more at **www.eyemed.com/csmp**

Your pediatric vision benefits include:

Vision Care Services	In-Network Member Cost
Exam with Dilation and Retinal Imaging as necessary	$0 Copay, including no cost retinal imaging.
Frames Any available at provider location.	100% coverage for provider designated frames.
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Standard Progressive Lens Premium Progressive Lens	 $0 copay $0 copay $0 copay $0 copay $0 copay See fixed premium progressive price list
Lens Options UV Treatment Tint (solid and gradient) Standard plastic scratch coating Standard polycarbonate - kids under 19 Standard anti-reflective coating Polarized Oversized Photochromatic/Transitions Plastic Premium anti-reflective coating Other add-ons	 $0 copay $0 copay $0 copay $0 copay $45 20% off retail price $0 copay $0 copay See fixed premium anti-reflective coating price list 20% off retail price
Laser Vision Correction LASIK or PRK from U.S. Laser Network	 15% off retail price or 5% off promotional price
Frequency Examination Frame & Lenses or contact lenses	 Once every calendar year Once every calendar year

OPTIONAL ADULT DENTAL, VISION AND FITNESS BENEFITS

When you enroll, we offer plans that provide benefits for Adult Dental, Vision and Fitness benefits. These plans have "Dental, Vision and Fitness" in the plan name. You can find your plan name on your CareSource ID card. These plans include all the same great essential health benefits as the standard plans, but provide additional dental, vision and fitness benefits to help consider your overall health.

These additional benefits are available for adults only. Pediatric vision and dental benefits are available to children until they reach the age of 19.

The additional benefits are summarized below, but you should review your EOC and Rider for additional detail on what is covered, and your Schedule of Benefits for your cost sharing amounts.

Adult Dental Care

In order to get your dental care benefits you must see a DentaQuest network provider. You can visit **www.dentaquest.com/members/** to register for a DentaQuest member portal account, where you can see your exact benefits and find dentists near you.

Dental benefits include:

- $1,000 annual allowance
- $0 cost share for diagnostic and preventive services, including two cleanings, two oral evaluations and imaging services.
- Basic restorative services (fillings), subject to cost share.
- Major restorative services (extractions, root canals, dentures and crowns), subject to cost share.

Refer to your Evidence of Coverage and Rider for full details about covered services, and your Schedule of Benefits for information on your plan's cost shares.

Dental care providers can be found by using our ***Find A Doctor*** tool on **CareSource.com**. Search for 'Dentistry' as the specialty to locate a provider near you. You may also call DentaQuest directly at 1-855-453-5281 to find a dentist near you or to get more information about your benefits.

Adult Vision Care

All vision care services are provided through the EyeMed network of providers. EyeMed is one of the largest vision networks in the country, and their providers can be found inside LensCrafters, Pearle Vision, Target Optical and hundreds of independent providers.

To find a provider, you can use our ***Find A Doctor tool***, or call EyeMed directly at 1-833-337-3129. When you schedule an appointment with a provider, tell them you have EyeMed insurance through CareSource and they will confirm your plan and benefits.

A retinal imaging exam is now included as one of your vision benefits beginning in 2022. It helps your optometrist or ophthalmologist check for diseases of the eye. In addition you get easy scheduling and extended hours, including evenings and weekends with most providers, online tools that you can use to shop and buy glasses, contacts and prescription sunglasses online, just like you would in the store.

Below is a table that shows the services and your costs using your the Adult Vision Care plan.

Vision Care Services	In-Network Member Cost
Exam with Dilation and Retinal Imaging as necessary	$0-$65 Copay or 40% coinsurance, including no cost retinal imaging
Frames, Lens & Options Package Any frame, lens and lens options available at provider location.	$250 allowance for frame, lens and lens options, 20% off balance over $250
Contact Lenses *(includes materials only)* Conventional Disposable Medically necessary	 $0 copay; $250 allowance, 15% off balance over $250 $0 copay; $250 allowance, plus balance over $250 $0 copay, Paid-in-Full
Laser Vision Correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price
Frequency Examination Frame & Lenses or contact lenses	 Once every calendar year Once every calendar year

You also get additional discounts:

- 40% off additional pair discount*
- 20% off non-prescription sunglasses
- 40% off any remaining frame balance*

*These discounts are offered at in-network providers only.

For more information about your Vision benefits (Pediatric and Adult), visit **www.EyeMed.com/csmp**, or call 1-833-337-3129 to speak to an EyeMed Customer Service representative.

The Active&Fit Program

With your Dental, Vision and Fitness plan, you are automatically an Active&Fit® member! You can join a network of over 11,000 fitness centers* and if you like, you can change centers monthly to explore different centers that may meet your needs. Your membership also includes a home fitness kit. You can choose from over 30 options, including barre, tai chi, boot camp, Pilates and more. Some kits include a wearable fitness device, such as Fitbit® or Garmin®.

In addition to the fitness center membership and home workout kit, you have access to many more great features offered on the Active&Fit website. Visit ActiveandFit.com to register and explore the features of the program.

- Get Started! Program: By answering a few online questions about your areas of interest, you will receive a customized program for your exercise of choice, including instructions on how to get started and suggested online workout videos.
- 8,000+ on-demand workout videos in the website digital library, for all fitness levels.
- The Active&Fit Connected™ tool for tracking your exercise and activity.
- With your fitness center membership, you also have access to the Premium fitness network, which includes an additional 7,000+ fitness center and studio choices, offering unique experiences like rock climbing gyms and rowing centers, each with a buy-up member price.
- Healthy Living Coaching: Receive over-the-phone lifestyle coaching with a trained health coach in areas such as fitness, nutrition, stress, and sleep.
- Online quarterly newsletter.

***Getting active just got easier*™ with the Active&Fit program.**

**Non-standard services at the fitness center that call for an added fee are not part of the Active&Fit program. The Active&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit, Active&Fit Connected!, and Getting active just got easier are trademarks of ASH. Fitness center participation varies by location and is subject to change. Home Fitness Kits are subject to change.*

Hearing Benefits

All CareSource members have access to hearing benefits through our partnership with TruHearing. Members can have a routine hearing test at no charge, then select from a variety of hearing aid devices , if needed. Get a hearing test and pick your hearing aid (if needed) in 4 easy steps:

1. Call TruHearing for an appointment.

When you call TruHearing, you'll be assigned a dedicated Hearing Consultant who will answer your questions about hearing aid options, programs, products and pricing. Your Hearing Consultant will also locate a highly qualified TruHearing audiologist or hearing instrument specialist near you and will set up your hearing exam appointment.

2. Have a hearing test with your provider.

Your office visit will be much like the visits you have with other health care providers and specialists. In about 45 minutes, your provider will conduct a comprehensive hearing exam and then review and discuss the results with you.

3. Select a hearing aid right for your needs and your budget.

If your exam shows you need treatment with hearing aids, your provider will tell you about your options; including technology levels, costs and styles. Your provider will take care of ordering your hearing aids. The TruHearing Choice program lets you choose from a range hearing aids that have a discounted cost from $695 and up.

4. Pick up your hearing aids.

When you pick up your hearing aids, you'll have them custom programmed and adjusted to match your hearing loss. You will need two more follow up visits for adjustments to make sure the hearing aids are performing at their best for you.

TruHearing gives you ongoing support after you receive your hearing aids too. You get a 45 day trial period, a 3 year warranty, and low cost batteries available for you to order and have delivered directly to your home.

Call TruHearing at 1-866-202-2561 if you have any questions or want to make an appointment. You can also visit TruHearing.com to get started.

PHARMACY BENEFITS AND INFORMATION

CareSource RxInnovations®

Pharmacy Information

CareSource RxInnovations™ has partnered with Express Scripts to help you manage your prescriptions and save money.

Your prescription drugs and some prescription medical supplies from the pharmacy are covered by your plan. You can get your prescriptions at any pharmacy that is in-network with CareSource. Go to **CareSource.com/marketplace** and use the ***Find a Pharmacy*** Quick Link on the left side of the page to find a pharmacy near you.

Here are some more important facts about CareSource prescription drug coverage:

- You have to go to a pharmacy that accepts CareSource Marketplace to get your prescriptions.
- You will need to show your CareSource member ID card and your prescription at the pharmacy. Your ID card will let the pharmacy know you are a CareSource member.

- You may have copayments, a deductible, and/or coinsurance for your prescriptions, depending on your plan.
- Some medicines may have limits on how much can be dispensed to you at one time. This is called Quantity Limits (QL).
- Some medicines may require you try another medicine first before CareSource will cover it. This is called Step Therapy (ST).
- Some medicines require our prior authorization before it can be covered by your plan. The health partner who orders the drug should get the prior authorization. The prior authorization requirements for your medicines may change.

Network Pharmacies

In order to have your prescriptions covered by CareSource, you must get them filled at a pharmacy in our network. Our network includes most major plus many smaller pharmacies. We also have mail-order pharmacies in our network. Some of our larger network pharmacies include CVS, Kroger, Rite-Aid, and Wal-Mart.

To see a full list of network pharmacies, go to our ***Find a Pharmacy*** tool at **CareSource.com/marketplace**.

Now you can also get 90 day prescriptions for maintenance medications at your local pharmacy. Although it is the same cost as your monthly prescriptions, it may be a more convenient option for you.

Mail Order Prescriptions

If you are taking maintenance drugs for an ongoing (chronic) condition, you can get 90-day supplies sent to directly to you. Be sure to tell your provider you want to use the Express Scripts mail order service. Express Scripts mail order prescriptions can save you money, too. You can get your prescription at 2.5 times the monthly cost. Its like getting your third month at half price.

You can register for an account at **express-scripts.com/rx** to manage your prescriptions

Specialty Pharmacy

CareSource works with Accredo Specialty Pharmacy to supply specialty medications that your doctor may prescribe. Specialty drugs might be ordered when you have a chronic or difficult health condition. They typically require special handling or monitoring, or special administration. If you have been prescribed specialty drugs, Accredo can:

- Help you get your prescription filled or moved from your current pharmacy
- Deliver your specialty medications to your home, workplace or doctor's office
- Help you learn about your specialty medication and give you support from specially-trained health care professionals

For more information, call Accredo at 1-866-501-2009. They can take your call Monday through Friday from 7:30 a.m. to 9 p.m. Eastern Standard Time (EST).

You may also access the Accredo website at Accredo.com in order to manage prescription refills for existing specialty mail order medications as well as check coverage information.

Prescription Drugs

You deserve to have the safest, most cost-effective drugs for your needs. We use a Marketplace Drug Formulary, also known as a Formulary, to list our covered medications. The Formulary can be found on the Pharmacy pages of our website. If you do not have access to the Internet, Member Services can assist you or send you a printed copy of the formulary.

Drugs are categorized into tiers that represent different cost-sharing amounts. To learn more about how to use our Formulary, look in the introduction section of the document. Some drugs may have limits on how much can be dispensed to you at one time, called quantity or dosing limits. These are shown in the Formulary with a (QL) after the name of the medication. You may need to try one drug before taking another, called step therapy. Those drugs that require step therapy are shown in the Formulary with a (ST) after the name of the medication. The Formulary also tells you how to request a drug that is not on our Formulary.

Covered Prescriptions

Using our ***Find My Prescriptions*** online tool is a quick way to confirm that your prescriptions are covered and estimate their costs. Drugs on the CareSource formulary are placed in six different levels or tiers. Each tier has a different cost-sharing amount. Find My Prescriptions can be accessed from **CareSource.com/marketplace**, or through your My CareSource member portal account.

Find My Prescriptions can be found on **CareSource.com/marketplace** under ***Quick Links*** on the left side bottom of any page, or on the ***Tools and Resources*** menu. After you select your plan, you can search by drug name (generic or brand). This tool will confirm coverage, if prior approval is needed, and your cost. The costs you'll see assume that you **have not met** your deductible or maximum out-of-pocket (MOOP) costs that are required by your plan.

If you access the tool through your MyCareSource.com account, the cost you'll see is based more accurately on your current deductible and MOOP status. The cost shown in your My CareSource account may be lower than that shown on **CareSource.com**, if you have met your deductible. It is important to note that because of frequent changes in the price of medications, your prescription costs may not be exact.

Some out-of-state pharmacies do not take CareSource, but most chain drug stores across the country do. If you think you will travel out of our service area, it's best to fill your prescriptions before you leave. You can also use our ***Find a Pharmacy*** tool to confirm if there is a pharmacy in your area.

Call Member Services if you have questions or want a printed copy of the Formulary.

Prior Authorization for Prescriptions

We may also require your provider to submit clinical information to us to explain why a specific drug is being used (called a clinical prior authorization). These are also called Utilization Management reviews. We must approve the request before you can get the drug. These requirements help limit misuse and abuse, and ensure you get the most appropriate drugs for your condition. Drugs not listed on the Formulary are generally not covered without the approval of an exception request.

A prior authorization request from your provider tells us why a certain drug and/or a certain amount of a drug is needed. We must approve the request before the drug will be covered by your plan.

You can find out if a drug requires prior authorization by reviewing the CareSource Marketplace Drug Formulary on the **Drug Formulary** page. These are shown in the formulary with PA after the name of the medication. Some medications billed on your medical benefit may also require prior authorization. Please check the Authorization Requirements for Medications on the Medical Benefit.

We may not approve a prior authorization request for a drug. If we don't, we will send you information about how you can appeal our decision.

Opioid drugs must meet the following prior authorization requirements:

- Less than 90 days of therapy in the last 365 days
- No concurrent therapy with benzodiazepines
- All extended release opioids require prior authorization

Drug Safety Recalls

Sometimes, the federal government issues drug recalls. To find out if a drug you take is being recalled, please check the listings on the U.S. Food & Drug Administration website at **https://www.fda.gov/Safety/Recalls/**

Medication Therapy Management

Your health can depend on taking your medications the right way. Some drugs need to be taken at a certain time, with or without food and more. That's why we offer a Medication Therapy Management (MTM) program for our members. This program can help you learn more about your medications, prevent or address medication-related problems, decrease your costs, and stick to your treatment plan.

The MTM program may be available from your local pharmacists if they have chosen to take part. In many cases, a pharmacist will reach out to you and ask if you are interested in learning more about your medications. They ask because they want to help you. Through this program, your local pharmacist may get alerts and information about your medications and decide you may benefit from extra attention. They offer ways to help you with your medications and how to take them the right way. They will also work with your provider and others to address your needs and improve how you use your medications. The pharmacist may ask to schedule time with you to go over all of your medications, including any pills, creams, eye drops, herbals or over-the-counter items.

This service and the pharmacist's help and information are all part of being a CareSource member and are available at no cost to you. You can request this service as well, by asking your local pharmacist, or by calling Member Services to find out where you can go to discuss your medications with a pharmacist.

MTM Benefits to Members and Health Partners

- Improves safe use of medications
- Provides better coordination of care with all your doctors and other caregivers
- Gives you more information about your medications and how to use them correctly
- Adds another person to help you with your overall health care

Disposing of Medications Safely

If you have old or unused medications in your home, don't just throw them away or flush them down the toilet. There are ways to get rid of unused drugs safely.

Expired or unused drugs can be a health risk for toddlers, teens, and family pets. About 50,000 children visit the emergency room each year from taking medications that were within their reach. They can also be misused. Studies show that more than 70% of people who misuse prescription drugs get them from friends or family. Over 30,000 overdose deaths each year are due to prescription drugs.

There are ways to get rid of old or unused drugs safely:

DisposeRx® Packets

You can get free DisposeRx packets to help you get rid of expired drugs or medications you no longer use. These packets are safe for the environment, easy to use, and can help stop drug misuse. Please visit **https://secureforms.caresource.com/en/DisposeRx/** and complete the form to get your free DisposeRx packet.

Drug Take Back Day

The U.S. Drug Enforcement Administration (DEA) sponsors the National Prescription Drug Take Back Day each year. Go to **takebackday.dea.gov** to learn more.

Year-Round Drug Disposal

There are sites open year-round that take medications and prescription drugs you no longer use. Go to **deadiversion.usdoj.gov/drug_disposal** for more information and to find a disposal location near you.

MEMBER EXCLUSIVE PROGRAMS

Member Exclusive Programs and Tools

As a CareSource member, you have access to many exclusive programs for in-person and online help with your health and understanding your plan. These tools are meant to augment your care from a provider, not replace it. Please consult the appropriate provider if you need help with a physical or behavioral health issue.

MyHealth

All CareSource members over the age of 18 can use our new MyHealth tool on **MyCareSource.com** to explore healthy living tips and suggestions.

What does good health mean to you? Have you ever asked yourself “How healthy am I?” or “Could I be healthier?” CareSource may have the answers to your questions.

Now you can take a FREE online **health needs assessment (HNA)** that will help you understand how you can be healthier. It’s quick and easy to take. Sign in to your My CareSource account, and click the ***Health*** tab at the top of the screen. Then click ***Start*** next to the Health Needs Assessment under Assessments.

When you finish, you’ll get your personal health score and a plan to help you live a healthier life. You can also set up your own account page, build a profile and set goals and preferences.

myStrength

Take charge of your mental health and try our wellness tool called myStrength. This is a safe and secure tool designed just for you. It offers personalized support to help improve your mood, mind, body and spirit. You can access it online or on your mobile device at no cost to you. The myStrength program offers online learning, empowering self-help tools, wellness resources and inspirational quotes and articles.

You can access myStrength through the member portal at **MyCareSource.com** or by going to **https://www.mystrength.com/r/caresource** for more information and to sign-up. Complete the myStrength sign-up process and personal profile to get started. You can also download the myStrength app for iOS and Android devices at **www.mystrength.com/mobile** and sign in using your existing myStrength login email and password.

While myStrength may be helpful, and gives you tools you can use to improve your outlook, it cannot replace professional medical advice, diagnosis or treatment provided by a qualified medical or mental health professional. Please do not delay seeking care or disregard professional advice because of information you have read on myStrength or received from CareSource.

MyResources

Do you want help with social needs? Use CareSource's **MyResources** tool to connect with local low-cost and no-cost community programs and services. You can find it on your personal **MyCareSource.com** account page.

Find resources for help with:

- Food
- Shelter
- Health care
- Work
- Financial assistance
- And more

We have programs serving every zip code in the U.S., from small towns to large cities, with more being added each day.

You can also call CareSource Member Services to help you locate resources near you.

MyHealth Rewards

Make Life More Rewarding!

You can earn rewards for taking a proactive role in your own health and well-being. Our lifestyle rewards program encourages you to participate in various annual wellness visits and preventive care programs.

The My CareSource/MyHealth Rewards program lets you earn up to $70. The table below shows the rewards available to you.

Take charge of your health with our online wellness rewards program, MyHealth Rewards. As a CareSource member, you are automatically enrolled in the program. Below is the list of activities you can earn rewards for completing. When you complete an activity, your doctor will file a claim for the service. After we receive the claim, we will update your reward in your MyHealth account. You can access your MyHealth account from the ***Health*** tab in the your **MyCareSource.com** member portal account. You can redeem your rewards for a gift card from one of many retailers.

Rewardable Activity	Frequency	Amount of Reward	Population
Annual Physical Exam	1x/benefit year	$20.00	All adults 18+
HBA1c Test	1x/benefit year	$25.00	Adults with a diabetes diagnosis
Retinal Eye Exam	1x/benefit year	$20.00	Adults with a diabetes diagnosis

Rewards are subject to change. The rewards available to you will vary depending on your health care needs. Please note that not all reward activities are covered services annually. You may be responsible for the cost if you do not check with CareSource or your primary care provider (PCP) before receiving services.

Care Management and Outreach Services

Did you know CareSource offers personalized care and educational resources to our members? Our team of nurses and social workers offer individualized assistance with you in mind. We want to work with you, your family, and your providers to help you coordinate your care and ensure you have all you need to best manage your own health and lifestyle. You can get a nurse or social worker to help you streamline your health care by having one point of contact at CareSource. You will be given their direct phone line, so you can call with questions or concerns. Our team can help you:

- Find more affordable options for medications and supplies
- Provide education about chronic and acute illness
- Connect you to community resources
- Explain benefits and services available to you
- Help you understand your plan's coverage
- Make sure you have after hours support

A Care Manager may contact you if you or your doctor requests it, or if we feel our services might be helpful to you or your family.

CareSource offers Care Management for conditions that include, but are not limited to:

- Asthma
- Bipolar disease
- Chronic obstructive pulmonary disease / heart failure / coronary artery disease
- Controlled substance management
- Diabetes
- Depression
- Emergency department management
- High blood pressure
- High-risk pregnancy
- Pain management

A Care Manager may ask you questions to learn more about your health. We will give you information to help you understand how to care for yourself and access services and local resources.

We can talk to your PCP and other service providers to make sure you receive coordinated care. Our care managers can help you with other health conditions too.

Please call us if you have any questions about Care Management or feel that you would benefit from care management services. We are happy to assist you. You can call the Care Management assessment team at **1-833-230-2011**, Monday through Friday from 7 a.m. to 6 p.m. Eastern Standard Time.

Care Transitions

When you are discharged from the hospital, information comes at you fast. Our Care Transitions program helps you and/or your family members to:

- Answer any questions you may have related to discharge
- Ensure that you and/or your family members understand your medications and answer any questions related to your medications
- Help coordinate your PCP and/or specialist appointments
- Help coordinate your or your family's needs when you get home

If you or your family member wants or needs help when being discharged from the hospital, you can reach a member of the Care Transition team at **1-833-230-2011**, Monday through Friday from 7 a.m. to 6 p.m. Eastern Standard Time.

Disease Management

Living with a health condition can be hard. We have free disease management programs that can help you learn more about your health and better manage your specific health conditions. We want you to have the right tools to stay as healthy as possible.

The disease management programs can help you with:

- The MyHealth online tool (for members 18+) lets you participate in a 'journey' to improve your health.
- Materials with helpful tips and information to manage your condition and promote self-management skills.
- Care coordination with outreach teams.
- One-to-one care management (if you qualify).

We may receive information from your doctor, pharmacy, or other health care source letting us know that you would benefit from a program. We will send you materials related to your health condition along with tips and resources to help you self-manage your condition. All ages (children, teens and adults) are eligible to participate in a program. You can self-refer or be referred into a disease management program to receive condition specific information or outreach.

Please call us if you would like more information about your health condition or would like to be a part of a disease management program. Call us at **1-844-438-9498**. If you do not want to receive further materials or outreach, please call us at the number above.

Express Banking from 5/3 Bank

Your financial health can play a part in your overall health and wellness. Express Banking® is a bank account from Fifth Third Bank with no monthly service charge, no balance requirement, no overdraft fees and a debit card for purchases. Visit 53.com/CareSource for more information.

Express Banking is provided by Fifth Third Bank.

ENSURING YOUR QUALITY OF CARE

Grievances and Appeals

We hope you will be happy with CareSource and the service we provide. If you are unhappy with anything about CareSource or our providers, let us know as soon as possible. Even if you do not agree with a decision we have made, please contact Member Services. You or your authorized representative can contact us with a complaint.

In order for CareSource to talk to your authorized representative about your grievance or appeal, you and your authorized representative must complete the Appointment of Authorized Representative form or the HIPAA Authorization form included in the appendix of this handbook. The form is also available online on the ***Forms*** page under ***Tools and Resources***. Return the completed form to us by mail or fax.

If you cannot get this form online, you can ask that it be mailed to you by calling Member Services.

If you are not satisfied, you have the right to:

- File a complaint (also called a grievance)
- File an appeal
- Ask for an external review

What is a Grievance?

A grievance is an official complaint. This is the first step of the review process if you are unhappy with your benefits and services or if you do not agree with a decision that was made regarding your medical care. Examples of a grievance include, but are not limited to:

- You cannot get a timely appointment with a provider.
- You think the provider's office staff did not treat you fairly.
- You are not satisfied with the quality of care you received.
- CareSource denies a service.
- CareSource gives partial approval to cover a service.
- CareSource denies payment of a service.

We will send you a letter letting you know the outcome of the grievance review. If you do not agree with the decision, you can file an appeal.

What is an Appeal?

If you do not agree with the outcome of the grievance, you have the right to appeal. An appeal is a request to reconsider and change the decision made or the action taken.

For more specific information about any of these topics, please see your plan's Evidence of Coverage on the **Plan Documents** page.

What is an External Review?

External reviews are conducted by Independent Review Organizations. If you are unhappy with a decision CareSource made in response to an internal appeal that you filed regarding a denial to cover or pay for a service, you may request an external review. In most cases, you must go through all of the steps in the internal appeal process before you can ask for an external review.

Need Additional Help?

If you have questions about your rights or need help, please refer to the evidence of coverage for your CareSource plan or call Member Services.

You may also write to us at:

CareSource
Attention: West Virgina Member Appeals
P.O. Box 1947
Dayton, OH 45401

Clinical Practice and Preventive Guidelines

Your health is important. Clinical and preventive guidelines can help you and your providers understand the latest research and guidance regarding diagnosis, management, and treatment of specific health conditions. They help guide your provider in giving you the best possible care.

Health information and these guidelines are available to you through member newsletters, and the CareSource member website. Preventive guidelines and health links are available to members and providers on the website or in print.

We review our guidelines at least every two years, and they are updated as needed. The updated guidelines are then presented to the CareSource Quality Enterprise Committee for adoption.

Topics for our guidelines are identified by analyzing CareSource member data. Guidelines may include, but are not limited to:

- Behavioral Health (i.e., depression or anxiety)
- Adult Health (i.e., hypertension or diabetes)
- Child/Adolescent Health (i.e., immunizations or well care)
- Population Health (i.e., obesity or tobacco cessation)

If you have any questions or would like to see a copy of our guidelines, please call Member Services.

Utilization Management (UM)

Utilization Management (UM) is when CareSource reviews a request for certain health care services either before, during, or after service. We will review the request for the medical necessity, efficiency or appropriateness of health care services and treatment that our members receive. We use clinical guidelines and current accepted practices to review your care and service.

Access to Utilization Management Staff

- Our staff is available from 8 a.m. to 5 p.m. Eastern Standard Time (EST) for calls about UM issues. Call Member Services and ask for the Utilization Management department.
- If you do not speak English, Member Services can also provide you with interpreter services.
- For assistance with UM issues outside of normal business hours, you may leave a voicemail message.
- You can also contact us electronically through our website. Visit the **CareSource.com** homepage and click ***About Us***, then ***Contact Us***, to access the "Tell Us" form.
- Voicemails or emails received after normal business hours are returned on the next business day and communications received after midnight on Monday through Friday are responded to on the same business day.
- Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues.

You can contact us anytime about UM issues or prior authorization requests.

We use current clinical information and generally accepted guidelines to guide clinical decision making. We do not give rewards to health partners or employees for not providing services to you, and we do not encourage or reward health care decisions that could reduce services to members.

Review of New Technology

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

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

Coverage is based on one or more of the following:

- Health Insurance Marketplace rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

Quality Improvement Program

Program Purpose

Your care means a lot to us. CareSource continually reviews the quality of care and service offered to our members. We put programs in place to improve how we provide health care services to members, help members with their health outcomes, such as our Disease Management Program and Care Management Services, and how we work internally.

Our Quality Improvement Program receives a written evaluation each year. This helps determine how well our quality improvement activities are working. A cross-functional team participates in the evaluation process.

In 2017, CareSource was awarded an accreditation status of Accredited by the National Committee for Quality Assurance (NCQA®). This accreditation status shows our commitment to service and clinical quality that meets or exceeds requirements for consumer protection and quality improvement.

Program Scope

CareSource supports an active, ongoing, and comprehensive Quality Improvement Program.

- The Quality Improvement Program will:
- Advocate for members
- Meet member access and availability needs for physical and behavioral health care
- Demonstrate enhanced care coordination and continuity for members across settings
- Meet members' cultural and language needs
- Monitor important aspects of care to ensure the safety of members across health care settings
- Determine provider adherence to clinical practice guidelines
- Support member self-management efforts
- Work collaboratively with network partners, practitioners, regulatory agencies, and community agencies
- Develop interventions that improve and support members' acute and chronic health conditions and complex needs
- Develop interventions that enrich member and health partner experiences and overall satisfaction
- Ensure regulatory and accrediting agency compliance

Quality Measures

CareSource uses an annual member survey for our marketplace members, *Qualified Health Plan Enrollee Experience* to capture member perspectives on health care quality. You might receive a request to complete this survey. Your experiences and opinions are important to us. Please complete the survey promptly.

This is a quality program overseen by the United States Department of Health and Human Services — Agency for Healthcare Research and Quality (AHRQ). Potential quality measures for the Health Insurance Marketplace include:

- Customer Service
- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Ratings of All Health Care, Health Plan, Personal Doctor, Specialist

We continually assess the quality of care and services offered to you. We use an objective monitoring and evaluation system to create programs that will improve your health outcomes.

CareSource uses the Healthcare Effectiveness Data and Information Set (HEDIS®) to measure the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by The National Committee for Quality Assurance (NCQA).

The HEDIS tool is used by America's health plans to measure important dimensions of care and service, and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures evidence-based care and addresses the most pressing areas of care. Potential quality measures for the Health Insurance Marketplace include:

- Wellness and Prevention
  - Preventive Screenings (breast cancer, cervical cancer, colorectal cancer, etc.)
  - Well-Child Care
- Chronic Disease Management
  - Comprehensive Diabetes Care
  - Controlling High Blood Pressure
- Behavioral Health
  - Follow-up After Hospitalization for Mental Illness
  - Antidepressant Medication Management
- Safety
  - Use of Imaging Studies for Low Back Pain

HEDIS® and NCQA® are registered trademarks of the National Committee for Quality Assurance. CMS evaluates qualified health plans (QHPs) offered through the Marketplace using QHP Enrollee Survey response data. QHP issuers contract with HHS-approved survey vendors that independently conduct the survey each year. QHP Enrollee Survey results may change from one year to the next. For more information, please see CMS' Health Insurance Marketplace Quality Initiatives website at: ***http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Quality InitiativesGenInfo/Health-Insurance-Marketplace-Quality-Initiatives.html***

GLOSSARY

Definitions

Annual Deductible means the amount you must pay for some covered services in a benefit year before we will begin paying for certain benefits. Copayments do not count towards the annual deductible. Network benefits for defined preventive health care services are never subject to payment of the annual deductible. Your Schedule of Benefits will identify which benefits must meet the deductible.

Annual Out-of-Pocket Maximum means the maximum amount you pay in a benefit year related to benefits. When you reach the annual out-of-pocket maximum, benefits for covered services that apply to the annual out-of-pocket maximum are payable at 100% of eligible expenses during the rest of the benefit year. Payments toward the annual deductible, copayments and coinsurance for covered services will apply to your annual out-of-pocket maximum, unless otherwise noted below.

The following costs will never apply to the annual out-of-pocket maximum:

- Any charges for non-covered services;
- Copayments and coinsurance for adult dental, vision and fitness benefits or any other optional rider/ enhancement.

Even when the annual out-of-pocket maximum has been reached, you will still be required to pay:

- Charges for non-covered services;
- Charges that exceed the amount of our contracted fee.
- Copayments and coinsurance amounts for covered services available through the optional dental, vision and fitness rider/enhancement, and
- The amount of any benefits if you or your provider do not get prior authorization from us when required to do so under the terms of the plan.

Coinsurance means the charge, stated as a percentage of eligible expenses, that you are required to pay for certain covered services after the annual deductible is satisfied and until you reach your annual out-of-pocket maximum.

Copayment means the charge, stated as a flat dollar amount, that you are required to pay for certain covered services.

Covered Services means those health care services that are (1) covered by a specific benefit provision of the plan; (2) not excluded under the plan; and (3) determined to be medically necessary per the plan's medical policies and nationally recognized guidelines; and (4) that we determine to be all of the following: provided for the purpose of preventing, diagnosing, or treating a sickness, injury, behavioral health disorder, substance use disorder, or their symptoms; consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines, as described below; and not provided for the convenience of you, a Provider, or any other person.

> *In applying the above definition, "scientific evidence" and "prevailing medical standards and clinical guidelines" have the following meanings: "Scientific evidence" means the results of controlled clinical trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community. "Prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.*

Evidence of Coverage (EOC) – The EOC is an important legal document that describes the relationship between you and CareSource. It serves as your contract with CareSource, and it describes your rights, responsibilities, and obligations as a covered person under the plan. The EOC, including the Schedule of Benefits (SB), also tells you how the plan works and describes the covered services you and your dependents are entitled to, any conditions and limits related to covered services, the health care services that are not covered by the plan, and the annual deductible, copayments, and coinsurance you must pay when you receive covered services.

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

Marketplace Drug Formulary means a list that categorizes into tiers medications and products that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification. You can find out which tier a particular prescription drug has been assigned to by contacting CareSource Member Services at the toll-free number on your ID card or by logging onto **CareSource.com/marketplace** and going to the Pharmacy section.

Member has the same meaning as covered person. Covered person means an individual, including you, who is properly enrolled under the plan.

Network Provider means a provider who has entered into a contractual arrangement with us or is being used by us, or another organization that has an agreement with us, to provide certain covered services or certain administration functions for the network associated with the EOC. A network provider may also be a non-network provider for other services or products that are not covered by the contractual arrangement with us as covered services. In order for a pharmacy to be a network provider, it must have entered into an agreement with the pharmacy benefit manager (PBM) to dispense prescription drugs to covered persons, agreed to accept specified reimbursement rates for prescription drugs, and been designated by the PBM as a network pharmacy.

Plan means CareSource.

Premium means the monthly fee required from the plan subscriber (or owner),, in accordance with the terms of the plan.

Prior Authorization means any practice implemented by the plan in which benefits for a health care service is dependent upon a covered person or a provider obtaining approval from the plan before the health care service is performed, received, or prescribed, as applicable. This includes prospective or utilization review procedures conducted before providing a health care service.

Schedule of Benefits (SB) means the written description of the benefits that are available as covered services. The SB is provided to you with your new member kit, along with the EOC. The SB shows covered services and their associated costs.

Subscriber: The person who enrolled in the plan and is responsible for paying the monthly premium.

Summary of Benefits and Coverage (SBC) means the summary of benefits and costs for covered services that is provided to you when your enrollment is received by CareSource. The SBC includes examples of the coverage you will have for certain health events, such as a broken bone or pregnancy.

Note: Your EOC has more details about these terms and many more. You should read the entire EOC and keep it in a safe place for future reference.

APPENDIX
Additional Information and Forms

Advance Directives

You have the right to make Advance Directives. You sign these documents now in case you are not able to make your own health care decisions in the future. You can visit an attorney or your local legal aid office to have these papers drawn up for you*.

Advance Directives are used if you become unable to communicate because of an illness or injury. They let your doctor and others know your wishes concerning future medical care. You can also use them to give someone you trust the right to make decisions for you if you are not able. You sign them while you are still healthy and able to make such decisions.

We do not put any limits on your right to have an Advance Directive under state law.

** Please note: This is not legal advice and is provided for general information purposes only*

Mental Health Treatment Directive

You may state your preferences regarding the mental health treatment that you may or may not wish to receive in the event you become unable to make your own decisions. For example, you may only want to be treated at a certain facility or only be given certain medications.

For more information on how you can state your preferences on the mental health treatment you want to receive, contact your attorney or local legal aid service for more information.*

** Please note: This is not legal advice and is provided for general information purposes only.*

Guardianship

What is a Guardian?

A guardian is a person appointed by a court to be legally responsible for another person.

When Will a Guardian be Appointed?

A court will usually appoint a guardian to manage the personal affairs of an adult who can no longer make safe and sound decisions by themselves due to legal or mental incapacity. A minor may also have a guardian appointed by a court in certain situations.

How Do I Obtain a Guardianship?

Only a court may appoint a guardian. The court that usually appoints a guardian is your local probate court, although this may be different depending on where you live. Contact your local court, a local attorney or local legal aid service for more information on guardianship*.

If you obtain a guardianship for a CareSource member, please send a copy of the court documents to the CareSource *Privacy Office so that it may be added to the member's record. See the Privacy Notice Statement in this Appendix for the address and contact information for the Privacy Office.*

** Please note: This is not legal advice and is provided for general information purposes only.*

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is CareSource's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, the out-of-network providers **can't** balance bill you unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in the CareSource network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). We will pay out-of-network providers and facilities directly.
- CareSource generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

- Cover emergency services from out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility, and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the state department of insurance. Please call Member Services for more information on how to contact the department or find out more about your rights.

Visit **www.cms.gov** for more information about your rights under federal law.

Consent to Share Health Information

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

Other Uses and Disclosures

We typically use or share your health information in these ways:

To help you get health care treatment.

- We can use your health information and share it with experts who are treating you.
  Example: A provider sends us information about your diagnosis and care plan so we can arrange more care.

To run our company.

- We can use and give out your information to run our company and contact you when needed.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.
- We may use or share your health information to run our company.
  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.

To pay for your health care.

- We can use and give out your health information as we pay for your health care.
  Example: *We share information about you with your dental plan to arrange payment for your dental work.*

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

To help with public health and safety issues.

- We can share health information about you for certain reasons such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting harmful reactions to drugs
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

To do research.

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

To obey the law.

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

To respond to organ and tissue donation requests and work with a medical examiner or funeral director.

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner or funeral director when a person dies.

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

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

To respond to lawsuits and legal actions.

- We can share health information about you in response to a court or administrative order, or in response to a court order.

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

Our Responsibilities

We protect our members' health information in many ways. This includes information that is written, spoken or available online using a computer.

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

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

Effective date and changes to the terms of this notice
The original Privacy notice was effective April 14, 2003, and this version was effective June 13, 2018. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice and the new one would apply to all health information we keep. If this happens, the new notice will be available upon request and will be posted on our web site. You can also ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

The CareSource Privacy Officer can be reached by:

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

Email: **HIPAAPrivacyOfficer@caresource.com**

Phone: **1-855-202-0622, ext. 2023 (TTY: 711)**

Privacy Notice Statement

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. 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, then 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 have 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,
  - Amount paid,
  - 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 list within 12 months, then we will charge a fair, cost-based fee.

Get a copy of this privacy notice

- ou 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, then 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 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 using 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 by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not take action against you for filing a complaint. We may not require you to give up your right to file a complaint as a condition of:
  - Care,
  - Payment,
  - Enrollment in a health plan, or
  - Eligibility for benefits.

Your Choices

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

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

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

If you are not able to tell us your choice, such as if you are unconscious, we may share your information 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

Fraud, Waste and Abuse

CareSource has a program designed to handle cases of health care fraud. Providers or members can commit fraud. We monitor and take action on any member or provider fraud, waste and abuse. Some examples are:

Provider Fraud, Waste and Abuse

- Prescribing drugs, equipment or services that are not medically necessary
- Scheduling more frequent return visits than are medically necessary
- Billing for tests or services not provided to you
- Billing for more expensive services than provided

Member Fraud, Waste and Abuse

- Sharing or misusing your CareSource ID card with another person
- Selling prescribed drugs or other medical equipment paid for by CareSource to others
- Submitting false information
- Forging a doctor's signature on prescriptions, etc.
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Pharmacy Fraud, Waste and Abuse

- Providing drugs that are not according to the prescription
- Giving you a generic drug and send in a claim for a more expensive brand-name drug
- Giving you less than the prescribed drug amount without telling you and without giving you the rest of the amount you should receive

If You Suspect Fraud, Waste or Abuse

If you think a provider or a CareSource member is committing fraud, waste or abuse, you can report your concerns to us by:

- Calling Member Services (TTY 711) and selecting the menu option for reporting fraud. **Our Fraud, Waste and Abuse hotline is available 24 hours a day.**
- Visiting our website at **CareSource.com** and completing the Fraud, Waste and Abuse Reporting Form and mailing it to the address shown
- Sending us a letter addressed to:

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

You do not have to give us your name when you write or call. There are other ways you may contact us that are not anonymous. If you are not concerned about giving your name, then you may also use one of the following means to contact us:

- Fraud email: **fraud@CareSource.com**
- Fraud fax: **1-800-418-0248**

When you report fraud, waste or abuse, please give us as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your report will be kept confidential to the extent permitted by law.

Member Rights and Responsibilities

You have the right to:

- Receive information about CareSource, our services, our network providers, and member rights and responsibilities.
- Be treated with respect and dignity by CareSource personnel, network providers and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive.
- Participate with your provider in making decisions about your health care.
- Candidly discuss with your provider the appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Voice complaints or appeals about the plan or the care it provides.
- Make recommendations regarding the plan's Member Rights and Responsibilities policy.
- Choose an Advance Directive to designate the kind of care you wish to receive should you be unable to express your wishes.
- Be able to get a second opinion from a qualified network provider. If a qualified network provider is not able to see you, then CareSource will set up a visit with a provider not in our network.

You have the responsibility to:

- Provide information needed, to the extent possible, in order to receive care.
- Follow the plans and instructions for care that you have agreed to with your providers.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be enrolled and pay any required premiums.
- Report any suspicion of fraud, waste and abuse using the reporting mechanisms located in this handbook.
- Pay an annual deductible, copayments and coinsurance.
- Pay the cost of limited and excluded services.
- Choose network providers and network pharmacies.
- Show your ID card to make sure you receive full benefits under the plan.

SUMMARY OF THE WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

(Effective July 1, 2019)

Residents of West Virginia who purchase life insurance, annuities or health insurance should know that the insurance companies and health maintenance organizations licensed in this state to write these types of insurance are members of the West Virginia Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policy and contract owners, certificate holders and enrollees of covered policies and contracts will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurers for the money to pay the claims of covered persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these member insurers through the Guaranty Association is not unlimited, however, and, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The West Virginia Life and Health Insurance Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or health maintenance organization or in selecting an insurance policy or contract. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

Coverage is NOT provided for any portion OF YOUR CONTRACT that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies and health maintenance organizations or their agents are required by law to give or send you this notice. However, insurance companies, health maintenance organizations and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy or health maintenance organization coverage.

The Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have that are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712
West Virginia Insurance Commissioner

Consumer Services Division
900 Pennsylvania Avenue
P.O. Box 50540
Charleston, West Virginia 25305-0540 (304) 558-3386

Toll Free 1-888-879-9842 (TDD 1-800-435-7381)

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life, health or annuity policy, plan or contract, or if they are insured under a group life, health or annuity policy, plan or contract, issued by a member insurer. Member insurer also includes non-profit service corporations (W. Va. Code §33-24), health care corporations (W. Va. Code §33-25) and health maintenance organizations (W. Va. Code §33-25A). The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies, plans or contracts are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent member insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The member insurer was not authorized to do business in this state;
- The policy, plan or contract was issued at a time when the member insurer was not licensed or authorized to do business in the state;
- The policy, plan or contract was issued by a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policy, plan or contract holder is subject to future assessments, an insurance exchange, an organization that has a certificate or license limited to the issuance of charitable gift annuities or any entity similar to the above.

The Guaranty Association also does not provide coverage for:

- Any policy, plan or contract, or portion of a policy, plan or contract that is not guaranteed by the member insurer or for which the individual or contract holder has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy, plan or contract by a group contract holder;
- Employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  - i multiple employer welfare arrangement;
  - ii minimum premium group insurance plan;
  - iii stop loss group insurance plan; or
  - iv administrative services only contract;
- Any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension guaranty corporation;
- Any portion of any unallocated contract that is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery;
- Any policy, plan or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C and D or Medicaid;

- An obligation that does not arise under the written terms of the policy, plan or contract, including claims based on marketing materials, claims based on side letters or riders not approved by the Commissioner, misrepresentations regarding policy benefits, extracontractual claims or claims for penalties or consequential or incidental damages;
- A contractual agreement that establishes the member insurer's obligation to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or trustee, which is not an affiliate of the insurer;
- Structured settlement annuity benefits, the rights to which have been transferred by the payee or beneficiary in a structured settlement factoring transaction.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the member insurer would owe under a policy, plan or contract. Also, for any one insured life, regardless of the number of policies, plans or contracts, the Guaranty Association will only pay:

- $300,000 in life insurance benefits, but no more than $100,000 in net cash surrender and net cash withdrawal values;
- $300,000 for disability income insurance;
- $300,000 for long term care insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
- $500,000 for health benefit plans (W. Va. Code §33-26A-5(10)); and
- $100,000 for all other types of accident and sickness insurance coverages not defined as disability income insurance, long tem1 care insurance, or health benefit plans.

Also, for any one insured life, the Guaranty Association will only pay a maximum of $300,000-no matter how many policies and contracts there were with the same company-for all policies or contracts other than health benefit plans, in which case the aggregate limit shall not exceed $500,000 with respect to any one individual.

Note: to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under §§ 401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, per participating individual. In no event shall the Guaranty Association be liable to spend more than $300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of $5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

WV-EXCM-0774

Member Consent/HIPAA Authorization

This form lets CareSource Management Group Co. 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 Care Provider (PCP) 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.

Multi-EXC-M-677500

☐ **Dental services**
☐ **All other services**

Member Claim Form

CareSource™

A. SUBSCRIBER INFORMATION

1a. Member ID	2a. Health Plan	3a. Phone #: ( )	
4a. Last Name:	5a. First Name:	6a. MI:	7a. Date of Birth / /
8a. Home Address:			
9a. City:	10a. State:	11a. Zip Code:	

B. PATIENT INFORMATION

1b. Patient's Member ID:				
2b. Last Name:	3b. First Name:	4b. MI:	5b. Date of Birth / /	
6b. Home Address:				
7b. City:	8b. State:		9b. Zip Code:	
10b. Sex: M ☐ F ☐	11b. Relationship to Subscriber:	12b. Full Time Student: Yes ☐ No ☐	13b. School Name:	

C. ACCIDENT INFORMATION (if applicable)

1c. Accident Work ☐ Auto ☐ Other ☐	2c. Date Accident Occurred: / /
3c. How did the accident occur?	

D. OTHER INSURANCE

1d. Is the patient covered by another insurance plan? Yes ☐ No ☐ If yes, please complete the following:	
2d. Name of person carrying other insurance:	3d. Date of Birth / /
4d. Member ID:	5d. Name of Other Insurance Carrier:
6d. Policy Number:	7d. Employer Name:

8d. **ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OF ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES. I CERTIFY THAT THE INFORMATION SUPPLIED IS TRUE AND CORRECT.**

Member or Parent/Guardian Signature: _____ Date: _____

E. ASSIGNMENT OF BENEFITS

1e. Please sign below *only if you want CareSource to pay benefits directly to the provider* of medical services.

Member or Parent/Guardian Signature: _____ Date: _____

GUIDELINES FOR SUBMITTING CLAIMS TO CareSource

- Clip, do not staple, all bills to the completed form and mail them to **CareSource** at the address listed below.
- **Make sure all bills indicate a diagnosis code, procedure code, date of service and cost.**
- **Provide a copy of either a UB92 or HCFA1500 form (this form can be obtained from your provider of service.)**
- Please include your **Member #** on all documents, and submit all claims to CareSource in a timely manner.
- Submit claims to: **PO Box 8730, Dayton, OH 45401-8730**
- This form may not be used for pharmacy claims

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NOTES

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Health Care with Heart

CareSource®

1-855-202-0622
(TTY/TDD: or 711)
CareSource.com/marketplace

WV-EXC-M-862257