CareSource
Marketplace

# 2024 Evidence of Coverage

## Dental, Vision and Fitness Rider

**WEST VIRGINIA**

CareSource®


CareSource West Virginia Co.
400 Washington St. E Suite 401
Charleston, WV 25301

# ADULT DENTAL, VISION, AND FITNESS RIDER

This Rider is a part of the Evidence of Coverage (EOC) to which it is attached. It is subject to all of the terms, conditions, exclusions, and limitations of the EOC which are not in conflict with the terms, benefits, exclusions, and limitations of this Rider.

CareSource Adult Dental, Vision, and Fitness Rider includes the Benefits and services described in this Rider. They are offered at an extra cost to you, as further described in the Schedule of Benefits and may be referred to as "Adult Dental Benefits", "Adult Vision Benefits", and "Adult Fitness Programs". These Benefits are not Essential Health Benefits.

NOTE: Dental and vision Benefits for pediatric members are not available under this Rider. Please reference Section 5: *Your Covered Services* of your EOC for pediatric dental and vision Benefits.

**Network of Providers**

CareSource utilizes a Network for the provision of covered Adult dental and vision Benefits, and fitness programs. We will only provide coverage for Adult dental, vision, and fitness program Benefits when you use a dentist, optometrist, ophthalmologist, fitness center, or other appropriate Provider within our Network. We do not cover dental, vision, and fitness program services provided by Non-Network Providers except as allowed by in Section 3: *How The Plan Works*.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at caresource.com/wv-access-plan. You may also contact us at 1-833-230-2099 to request a copy.

## 1. ADULT DENTAL BENEFITS

The Benefits available to you under this section are administered by our Dental Benefits Manager. The management and other services they provide include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this section. You must use a Dental Benefits Manager Network Provider in order to receive Benefits under this section. If you do not use a Dental Benefits Manager's Network Provider to receive Health Care Services under this section, you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-855-453-5281 for help locating a Dental Benefits Manager Network Provider and for additional information and details.

You may view the Access Plan required by Health Benefit Plan Network and Adequacy Act online at caresource.com/wv-access-plan. You may also contact us at 1-833-230-2099 to request a copy. If there is not an in-network dental Provider in your area, you may request an out of network Provider to provide covered services to you. The out of network Provider will send a Prior Authorization request and if there are no in-

network Providers available to provide the covered service in the required time and distance standards, the request will be approved.

CareSource's Adult Dental Benefits include the following listed services. Services outside of those listed are not Covered Services. All Adult Dental Benefits under this section are subject to a combined $1000 limit per Benefit Year.

Dental (CDT codes) maintained by the American Dental Association, are listed in this section to help increase clarity to you and your Provider. There are times when delivery of new or modified dental procedures and the CDT Code maintenance process may result in changes following the finalization and publication of this Evidence of Coverage which may result in the replacement or removal of listed codes and or require the consideration of newly created codes. CareSource will evaluate these changes for administrative updates required to ensure our ability to continue to provide the coverage as intended by this section.

**Class I – Preventive Services**

- Dental prophylaxis (cleanings) (D1110) - limited to two (2) per Benefit Year. We generally expect there to be a six (6) month separation between services, even when the services enter a new plan year.

**Class I - Diagnostic Services and Other Services**

- Oral evaluations, including periodic, limited problem focused, and comprehensive oral and periodontal (D0120, D0140, D0150, D0180) are combined and limited to two (2) times per Benefit Year. Comprehensive oral evaluation (D0150, D0180) limited to one (1) per twenty-four (24) months per Provider or location.
- Intraoral - comprehensive set of radiographic images (including bitewings) or extraoral panoramic radiographic image (D0210, D0330) limited to once per sixty (60) months.
- Intraoral tomosynthesis (D0372, D0373, D0374, D0387, D0388, D0389).
- Periapical radiograph (x-ray) images (D0220-D0240) and bitewing images (D0270-D0277) are limited to maximum daily amount and will be payable to your Provider up to the amount of a comprehensive series for a single date of service. Bitewings (D0270-D0274) are further limited to a total of four horizontal bitewing films in any combination or one (1) set of vertical bitewings (D0277) per six (6) months. Interpretation of diagnostic image including report (D0391) limited to one (1) per image.
- Diagnostic casts (D0470) limited to one (1) per case per Provider or location.
- Minor palliative treatment of pain (D9110) per day.

**Class II – Minor Restorative**

- Amalgam and resin restorations (D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394) limited to one (1) per twelve (12) months per tooth per surface.
- Re-cement or re-bond inlay, onlay, post and core, or crown (D2910, D2915, D2920)-not reimbursable within six (6) months of initial placement.
- Protective restoration (D2940) limited to one (1) per Benefit Year per tooth.
- Pin retention (D2951) limited to a maximum of three (3) pins per tooth.

**Class II – Other Services**

- Periodontal maintenance (gum maintenance) (D4910) – in combination with routine dental cleanings(D1110, D1120) limited to four (4) total services per twelve (12) months Periodontal maintenance is payable to your Provider only if your dental records indicate active periodontal

therapy has been performed within the prior six (6) months and payable thereafter as ongoing continuous maintenance. Scaling and root planing (deep cleaning) (D4341, D4342) must be on file or documentation from patient record history of periodontal therapy with in the last six (6) months.

- Adjustments to dentures (D5410, D5411, D5421, D5422)- not covered within six (6) months of initial placement.
- Repairs to denture base and framework (D5511, D5512, D5611, D5612, D5621, D5622)- limited to repairs or adjustments performed more than twelve (12) months after the initial insertion.
- Repair or replace broken clasp or tooth (D5520, D5630, D5640)- not covered within six (6) months of initial placement.
- Add tooth or clasp to existing partial denture (D5650, D5660).
- Relining and rebasing dentures (D5710, D5711, D5720, D5721, D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761)- limited to relining/rebasing performed more than six (6) months after initial insertion - limited to one (1) time per thirty-six (36) months per code.
- Tissue conditioning (D5850, D5851).
- Extraction of erupted tooth or exposed root (D7140).
- Consultation with another dentist or Physician (D9310, D9311) limited to one (1) per day per code.

**Class III - Major Restorative Dental Services**

- Inlays (D2510, D2520, D2530) limited to one (1) per tooth per sixty (60) months per code. Covered only when a direct restoration will not adequately restore the tooth and limited to fully developed permanent teeth and primary teeth with no permanent successors.
- Onlays and crowns (partial to full) (D2542, D2543, D2544, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794) limited to one (1) per tooth per sixty (60) months. Limited to fully developed permanent teeth and primary teeth with no permanent successors. Onlays limited to metallic, and crowns limited to porcelain and metallic.
- Core buildup including pins (D2950) limited to one (1) per sixty (60) months per tooth.
- Post and core in addition to crown (D2952, D2954) limited to one (1) per sixty (60) months per tooth.
- Additional prefabricated posts (D2953, D2957) limited to one (1) per sixty (60) months per tooth per code.
- Crown, inlay, onlay, or veneer repair (D2980, D2981, D2982, D2983) limited to one (1) per sixty (60) months per tooth per code.

**Class III – Major Dental Services – Endodontics and Periodontics**

- Pulpotomy, therapeutic or partial (D3220, D3222). If a root canal is within forty-five (45) days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and Benefits are not payable separately.
- Pulpal debridement, primary and permanent teeth (D3221).
- Root canal (D3310, D3320, D3330) - limited to one (1) per tooth per lifetime per code.
- Retreatment of previous root canal (D3346, D3347, D3348) limited to one (1) per tooth per lifetime per code.
- Apexification/recalcification and pulpal regeneration including all phases (D3351, D3352, D3353, D3355, D3356, D3357) limited to one (1) per lifetime per tooth per code.
- Apicoectomy/periradicular surgery including additional roots (D3410, D3421, D3425, D3426) limited to one (1) per tooth/root per lifetime per code.
- Surgical repair of root resorption (D3471, D3472, D3473) limited to one (1) per lifetime per tooth per code.

- Surgical exposure of root surface without apicoectomy or repair of root resorption (D3501, D3502, D3503) limited to one (1) per lifetime per tooth per code.
- Root amputation and hemisection (D3450, D3920).
- Gingivectomy or gingivoplasty (D4210, D4211, D4212) limited to one per thirty-six (36) months per quadrant (per tooth for D4212).
- Gingival flap (D4240, D4241) limited to one (1) per thirty-six (36) months per quadrant.
- Clinical crown lengthening (D4249) limited to one (1) per thirty-six (36) months per tooth.
- Osseous surgery (D4260, D4261) limited to one (1) per thirty-six (36) months per quadrant.
- Various graft procedures (D4270, D4273, D4277, D4278) limited to one (1) per thirty-six (36) months per tooth per code.
- Scaling and root planing (deep cleaning) (D4341, D4342) - limited to one (1) time per quadrant per twenty-four (24) months.
- Full mouth debridement (D4355) limited to one (1) per lifetime.

**Class III – Comprehensive Dental Services – Removable Prosthodontics**

- Complete or immediate denture (D5110, D5120, D5130, D5140) limited to one (1) per sixty (60) months per maxillary or mandibular. Includes all adjustments within six (6) months of initial placement.
- Partial denture including immediate, resin base, or cast metal framework (D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224) limited to one (1) per sixty (60) months per maxillary or mandibular. Includes all adjustments within six (6) months of initial placement.
- Removable unilateral partial denture (D5282, D5283) limited to one (1) per sixty (60) months per code.

**Class III – Comprehensive Dental Services – Implants and Fixed Prosthodontics**

- Pontics – metal, porcelain, or ceramic (D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245) limited to one (1) per sixty (60) months per tooth.
- Retainer for fixed prosthesis (D6545, D6548, D6549) limited to one (1) per sixty (60) months per tooth.
- Fixed partial denture retainer inlays and onlays (D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634) limited to one (1) per sixty (60) months per tooth.
- Fixed partial denture crowns (D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794) limited to one (1) per sixty (60) months per tooth.
- Recement fixed partial denture (D6930)-not covered within six (6) months of placement.
- Fix partial denture repair, by report (D6980).

**Class III – Comprehensive Dental Services – Oral and Maxillofacial Surgery**

- Surgical removal of erupted tooth (D7210).
- Removal of impacted tooth, soft tissue, and various levels of bony (D7220, D7230, D7240, D7241).
- Surgical removal of residual tooth roots (D7250).
- Coronectomy (D7251), tooth reimplantation (D7270), and surgical access to unerupted tooth (D7280).
- Placement of device to facilitate eruption (D7283) limited to one (1) per lifetime per tooth.
- Alveoloplasty in conjunction with extraction or not (D7310, D7311, D7320, D7321) limited to one (1) per lifetime per quadrant per code. Minimum of four extractions and must be associated to the construction of a prosthodontic appliance.

- Removal of exostosis (D7471).
- Incision and drainage of abscess (D7510, D7520).
- Suture of small wound (D7910).
- Excision of pericoronal gingiva (D7971).

**Class III – Other Services**

- Deep sedation/anesthesia (D9222, D9223). First fifteen (15) minutes limited to one (1) per day, while each subsequent fifteen (15) minutes is limited to four (4) per day. Maximum of a combined ten (10) units or one hundred and fifty (150) total minutes per benefit period.
- Intravenous sedation/anesthesia (D9239, D9243). First fifteen (15) minutes limited to one (1) per day, while each subsequent fifteen (15) minutes is limited to four (4) per day. Maximum of a combined ten (10) units or one hundred and fifty (150) total minutes per benefit period.
- Therapeutic parenteral drug (D9610) limited to one (1) per day.
- Treatment of complications (post-surgical), by report (D9930).
- Occlusal guard (D9944) limited to one (1) per twelve (12) months for age 13 and older.

**Class IV –Orthodontics**

- No coverage for orthodontics.

**Exclusions**

The Plan does not cover the following:

- Services provided by Providers not within the Dental Benefit Manager's Network of Providers.
- Adult Dental Services and treatments not listed within this Rider.
- Services and treatment not prescribed by or under the direct supervision of a dentist, except for eligible Covered Services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
- Services and treatment which are not Medically Necessary, or which do not meet generally accepted standards of dental practice;
- Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
- State or territorial taxes on dental services performed;
- Those submitted by a dentist, which is for the same services performed on the same date for the same Covered Person by another dentist;
- Those performed by a dentist who is compensated by a Facility for similar Covered Services performed for Covered Persons;
- Duplicate, provisional and temporary devices, appliances, and services;
- Plaque control programs, oral hygiene instruction, and dietary instructions;
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
- Gold foil restorations;
- Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
- Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
- Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (Inpatient or Outpatient);

- Charges by the Provider for completing dental forms;
- Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners;
- Sealants for permanent teeth;
- Precision attachments, personalization, precious metal bases and other specialized techniques;
- Replacement of dentures that have been lost, stolen or misplaced;
- Repair of damaged orthodontic appliances;
- Replacement of lost or missing appliances;
- Fabrication of athletic mouth guard;
- Internal bleaching;
- Nitrous oxide;
- Oral sedation;
- Intravenous sedation;
- Topical medicament center;
- Orthodontic care for a Covered Person or spouse;
- Bone grafts when done in connection with extractions, apicoectomies or non-covered/non eligible implants.
- Except for Emergency Health Care Services, Dental Care Services received from a Non- Network Provider unless authorized by us.

## 2. VISION BENEFITS

**Network of Providers**

The Benefits available to you under this section are administered by EyeMed®. The management and other services that EyeMed provides include, among others, maintaining and managing the Network Providers who will provide Covered Services to you under this section. You must use an EyeMed Network Provider in order to receive Benefits under this section. If you do not use an EyeMed Network Provider to receive Health Care Services under this section, you will be responsible for all costs, and such Health Care Services will be considered Non-Covered Services. Please call 1-833-337-3129 for help locating an EyeMed Network Provider and for additional information and details.

You may view the Access Plan required by Health Benefit Plan Network Access and Adequacy Act online at caresource.com/wv-access-plan. You may also contact us at 1-833-230-2099 to request a copy. If there is not an in-network vision Provider in your area, you may request an out of network Provider to provide covered services to you. The out of network Provider will send a Prior Authorization request and if there are no in-network Providers available to provide the covered service in the required time and distance standards, the request will be approved.

**IMPORTANT:** IF YOU OPT TO RECEIVE VISION CARE SERVICES OR VISION MATERIALS THAT ARE NOT COVERED SERVICES UNDER THIS PLAN, A PARTICIPATING NETWORK PROVIDER MAY CHARGE YOU HIS OR HER NORMAL FEE FOR SUCH SERVICES OR MATERIALS. PRIOR TO PROVIDING YOU WITH VISION CARE SERVICES OR VISION CARE MATERIALS THAT ARE NOT COVERED BENEFITS, THE VISION CARE PROVIDER WILL PROVIDE YOU WITH AN ESTIMATED COST FOR EACH SERVICE OR MATERIAL UPON REQUEST.

**Covered Services:**

- **Comprehensive Eye Exam with Dilation, if Medically Necessary**. Limited to one (1) per Benefit Year. Cost share applies.
- **Eyewear**: Covered in Full up to a $250 allowance per Benefit Year, limited to one (1) eyewear allowance per Benefit Year. Allowance may be used for glasses (frame, lenses, and lens options package) or contact lenses once per Benefit Year.
    - Eyeglasses (includes frames, lens, and lens options).
        - Frames, lens, and options: 20% discount on the balance after $250 allowance.
    - Contact lenses (includes materials only).
        - Conventional - 15% discount on the balance after $250 allowance.
        - Disposable - no discount after $250 allowance.
- **Low-Vision:** Low vision is a significant loss of vision but not total blindness.
    - **Supplemental Testing:** Diagnostic evaluation beyond a comprehensive eye examination including an ocular function assessment, measurements, visual field evaluations. Limited to one (1) per Benefit Year.
    - **Low Vision Aids:** Includes, but is not limited to spectacle-mounted magnifiers, hand-held or spectacle-mounted telescopes, hand-held and stand magnifiers, and video magnification. Limited to one (1) per Benefit Year.
- **Retinal Imaging Benefit**: Covered at no member cost share. Limited to one (1) per Benefit Year.
- **Medically Necessary Contact Lenses:** In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear.

  In the event that contact lenses are determined to be Medically Necessary, the contact lenses and associated services, including fit and follow-ups, will be Covered In Full with no limitation on the number of follow-ups required.

**Limitations**

The Plan will only provide Benefits for one (1) pair of glasses or contact lenses. You may purchase additional eyewear at your own cost, and you may receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses upon exhaustion of the Benefits above.

**Exclusions**

The Plan does not cover the following:

- Services and materials not meeting accepted standards of optometric practice;
- State or territorial taxes on vision services performed;
- Visual therapy;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Two pairs of eyeglasses in lieu of bifocals; or
- Insurance of contact lenses.

## 3. THE ACTIVE&FIT ENTERPRISE FITNESS PROGRAM

The Plan provides covered adults aged 18 and older with the ability to enroll in select fitness centers for the Benefit Year while enrolled in the Plan. Using the Active&Fit Enterprise™ fitness program is voluntary and is provided at no cost to you. Enrollment may give you access to cardiovascular equipment, strength training equipment, certain fitness classes, and other amenities, such as saunas, locker rooms, and pools, where available.

The Active&Fit Enterprise program also offers digital fitness choices with home fitness tools, including:

- Home Fitness Kits: You are eligible to receive one home fitness kit per benefit year from a variety of fitness categories, with some kits including a wearable device (e.g., Fitbit or Garmin).
- On-Demand Workouts: View a variety of workout videos for all fitness levels.
- Healthy Living Coaching: Coaches help you meet your fitness, nutrition, and lifestyle goals during scheduled phone sessions.
- Workout Plans: Receive a personalized workout plan to help you build a safe and healthy routine.

For more information on this program, how to enroll, available services in your area, and exclusions and limitations, please call Active&Fit Enterprise member services at the number found on the back of your ID card, or at ActiveandFit.com.

**Limitations:**

- Fees paid under this program, if required, do not count towards your Annual Out-of-Pocket Maximum, are non-refundable, are not prorated, and may be required to be paid to a third party and not CareSource.
- Available fitness or exercise centers \ may vary and change at any time. Enrolled adults may not have access to all services offered by the fitness center and some services may require the purchase of upgraded memberships.
- Prior to enrollment, please verify with the fitness center what services are included as part of this program and what services (if any) would require additional fees.
- Not all Covered Persons may be eligible to participate in this program. Available fitness centers may have certain restrictions for enrollment, such as age requirements.
- Enrollment in this program is limited to the current Benefit Year and while Covered Persons are enrolled in the Plan. If you disenroll or are terminated from the Plan during the Benefit Year, then you will no longer be able to access fitness centers.
- Home kits are subject to change.

This Rider amends and is incorporated into the EOC between you and CareSource. This Rider takes the place of any other issued to you by CareSource on a prior date. All coverage under this Rider shall begin at 12:00 midnight and shall end at 11:59:59 Eastern Standard Time.

Erhardt H. Preitauer
President and Chief Executive Officer
CareSource

**ENGLISH** - Language assistance services, free of charge, are available to you. Call: **1-833-230-2099** (TTY: 711).

**SPANISH** - Servicios gratuitos de asistencia lingüística, sin cargo, disponibles para usted. Llame al: 1-833-230-2099 (TTY: 711).

**NEPALI** - तपाईंका निम्ति निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन् । फोन गर्नुहोस्: 1-833-230-2099 (TTY: 711).

**KOREAN** - 언어 지원 서비스가 무료로 제공됩니다. 전화: 1-833-230-2099 (TTY: 711).

**FRENCH** - Services d'aide linguistique offerts sans frais. Composez le 1-833-230-2099 (TTY: 711).

**GERMAN** - Es stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Anrufen unter: 1-833-230-2099 (TTY: 711).

**SIMPLIFIED CHINESE** - 可为您提供免费的语言协助服务。请致电：1-833-230-2099 (TTY: 711).

**TELUGU** - భాషా సాయం సర్వీసులు, మీకు ఉచితంగా లభ్యమవుతాయి. కాల్ చేయండి: 1-833-230-2099 (TTY: 711).

**BURMESE** - ဘာသာစကားဆိုင်ရာအကူအညီဝန်ဆောင်မှုများအား သင့်အတွက် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ရန်: 1-833-230-2099 (TTY: 711).

**ARABIC** - تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم: 1-833-230-2099 (هاتف نصيّ: 711).

**URDU** - زبان کی معاونتی ترجمانی خدمات، آپ کے لیے بالکل مفت یا فری آف چارج دستیاب ہیں۔ کال کریں: 1-833-230-2099 (TTY: 711).

**PENNSYLVANIA DUTCH** - Mir kenne dich Hilf griege mit Deitsch, unni as es dich ennich eppes koschte zellt. Ruf 1-833-230-2099 (TTY: 711) uff.

**RUSSIAN** - Вам доступны бесплатно услуги языкового сопровождения. Позвоните по номеру: 1-833-230-2099 (TTY: 711).

**TAGALOG** - May mga serbisyong tulong sa wika, na walang bayad, na magagamit mo. Tumawag sa: 1-833-230-2099 (TTY: 711).

**VIETNAMESE** - Dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi: 1-833-230-2099 (TTY: 711).

**GUJARATI** - ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક ઉપલબ્ધ છે. 1-833-230-2099 (TTY: 711) પર કૉલ કરો.

**PORTUGUESE** - Serviços linguísticos gratuitos disponíveis para você. Ligue para: 1-833-230-2099 (TTY: 711).

**MARSHALLESE** - Jerbal in jibañ ikijen kajin, ejelok onean, ej bellok ñan eok. Kurlok: 1-833-230-2099 (TTY: 711).

# NOTICE OF NON-DISCRIMINATION

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

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

If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

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

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

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


Multi-EXC-M-1568660

CareSource®

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