October 2014

CareSource™

Health Care with Heart

Member Handbook

1-800-488-0134
(TTY for the hearing impaired: 1-800-750-0750 or 711)
CareSource.com

Contact Us

HOW TO REACH US

Member Services Department

Phone: 1-800-488-0134
(TTY for the hearing impaired: 1-800-750-0750 or 711)

Street Address: 230 N. Main Street, Dayton, Ohio, 45402

Hours: Monday through Friday, 7 a.m. to 7 p.m.

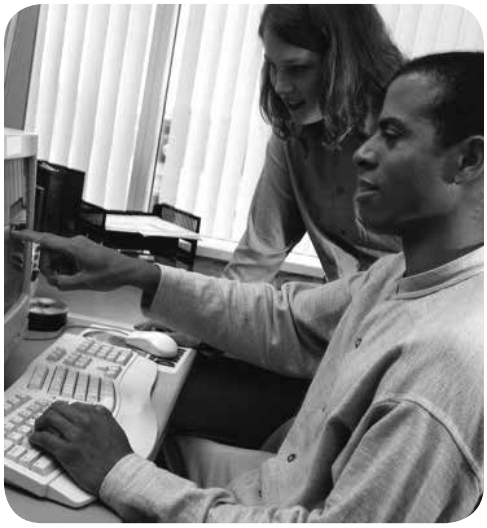
Online: CareSource.com

CareSource24®

Phone: 1-866-206-0554
(TTY for the hearing impaired: 1-800-750-0750 or 711)

CareSource® Transportation Services

Phone: 1-800-488-0134
(TTY for the hearing impaired: 1-800-750-0750 or 711)



Important Next Steps

Step 1

- Look for your ID card in the mail (see page 4)
  - You should get your member ID card in a separate mailing

Step 2

- Make an appointment with your doctor (see pages 5-6)
  - If you need to change your primary care provider (PCP), visit us online at **CareSource.com** and click on Find a Doctor/Provider on the right side of the page or call Member Services.

Step 3

- Read about your covered benefits and services (see pages 9-13)
  - You can also find information about your covered benefits and services online at **CareSource.com**

Step 4

- Fill out your Health Risk Assessment
  - CareSource wants you to stay healthy. You can help us by filling out your Health Risk Assessment
  - Fill out your assessment online by going to: **www.caresource.com/members/hra-health-risk-assessment/**

Thank you for choosing CareSource. Our mission is to improve your health. We are glad to have you as a member!

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CareSource™

If you have a problem reading or understanding this information or any other CareSource information, please contact our Member Services Department at ***1-800-488-0134*** *(TTY: 1-800-750-0750 or 711) for help at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.*

Welcome

Welcome to CareSource. You are now a member of a health care plan, also known as a managed care plan (MCP). CareSource provides health care services to Ohio residents eligible for Aged, Blind, or Disabled, Covered Families and Children including Healthy Start and Healthy Families, and adult extension Medicaid benefits.

Please read this handbook from cover to cover. It will answer many of the questions you might have. Or you can visit our website at **CareSource.com**.

HOW TO REACH US

If you ever have a question or need to contact CareSource, please call us at:

1-800-488-0134 (toll free)
TTY for the hearing impaired:
1-800-750-0750 or 711

Please let us know if you ever have a question or concern about your health care or our services. We want you to be a healthy and happy member of CareSource.

We like to hear what you think of CareSource. We welcome your suggestions for better service. If you want to tell us about things you think we should change, please call the Member Services Department. Your ideas are important to us.

Member Services Department

Our Member Services Department is open Monday through Friday from 7 a.m. to 7 p.m., except on the holidays listed on the next page. Our phone number is **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711).

We are located at **230 N. Main Street in Dayton, Ohio, 45402** and online at **CareSource.com**. For your convenience, we have also added a "Contact Us" page at the beginning of the handbook. You can call, email, or visit us online to:

- Ask questions about CareSource benefits, claims, eligibility, utilization management or prior authorization requests
- Find out what services are covered and how to access them
- Request a new member ID card
- Change your primary care provider (PCP)
- File a complaint about CareSource or a provider, or if you think you have been discriminated against
- Get help choosing a participating provider
- Let us know of changes to personal information, such as your address or phone number; you will also need to contact your county caseworker
- Let us know if you are pregnant
- Request interpreter services or if you or a family member are visually or hearing impaired and need help

Please give us a call. We want to make sure your concerns are taken care of and your questions are answered. Have your member ID number handy when you call. This will help us serve you faster.

After business hours, you can:

- Choose an option from our phone menu that meets your needs.
- Send an email at any time through our website. Just visit **CareSource.com**.

CareSource is closed on:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- The day after Thanksgiving
- The day before Christmas
- Christmas Day

A holiday that falls on a Saturday is observed on the Friday before it. One that falls on a Sunday is observed on the Monday after it.

INTERPRETER SERVICES

If there is a CareSource member in your family whose primary language is not English, is visually or hearing impaired, or has limited reading skills, please call us to arrange interpreter services. We offer sign and language interpreters for members who need language assistance communicating with CareSource or their health care provider. By calling the Member Services Department, you can arrange to get interpreter services over the phone or in person. We can also provide some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. This is a free service to you.

New Member Information

If you were on Medicaid fee-for-service the month before you became a CareSource member and have health care services already approved and/or scheduled, it is important that you call the Member Services Department *immediately* (today or as soon as possible). In certain situations and for a specified time period after you enroll, we may allow you to receive care from a provider that is not a CareSource panel provider.

Additionally, we may allow you to continue to receive services that were authorized by Medicaid fee-for-service. **However, you must call CareSource before you receive the care.** If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call the Member Services Department if you have the following services already approved and/or scheduled:

- Organ, bone marrow, or hematopoietic stem cell transplant
- Third trimester prenatal (pregnancy) care, including delivery
- Inpatient/outpatient surgery
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies, and nursing

After you enroll, the MCP will tell you if any of your current medications require prior authorization that did not require authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information CareSource provides and contact our Member Services Department if you have any questions. You can also look on our website at **CareSource.com** to find out if your medication(s) require prior authorization. You may need to follow up with the prescriber's office to submit a prior authorization request to CareSource if it is needed. If your medication(s) requires prior authorization, you cannot get the medication(s) until your provider submits a request to CareSource and it is approved.

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CareSource24® Nurse Advice Line

With CareSource24, you have unlimited access to talk with a caring and experienced staff of registered nurses through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource24 services are available at no cost to you. Our nurses can help you:

- Decide when self-care, a doctor visit or the emergency room is appropriate
- Understand a medical condition or recent diagnosis
- Prepare questions for doctor visits
- Find out more about prescriptions or over-the-counter medicines
- Get information on medical tests or surgery
- Learn about nutrition and wellness topics

To reach CareSource24, call 1-866-206-0554 (TTY for the hearing impaired: 1-800-750-0750 or 711).

Identification (ID) Cards

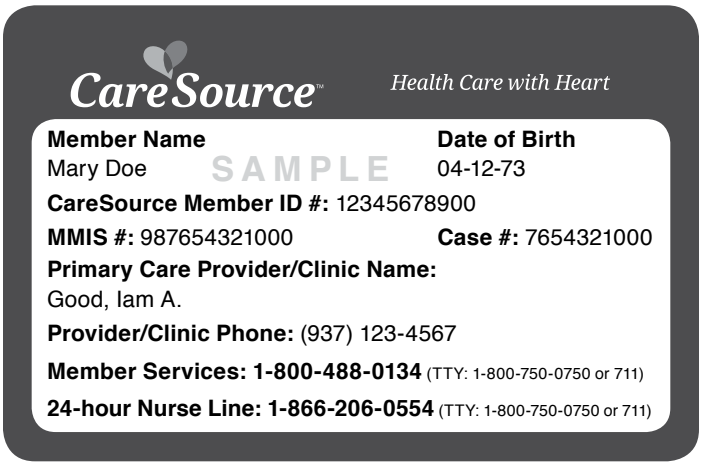
You should have received a CareSource membership ID card. Each member of your family who has joined CareSource will receive their own card.

Never let anyone else use your CareSource ID card.

These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of CareSource. You will not receive a new card each month as you did with the Medicaid card.

You will receive a new card if you request a replacement or if you change your Primary Care Provider (PCP).

If you are pregnant, you need to let CareSource know and also call when your baby is born so we can send you a new ID card for your baby.


CareSource™ *Health Care with Heart*

Member Name Mary Doe SAMPLE **Date of Birth** 04-12-73

CareSource Member ID #: 12345678900

MMIS #: 987654321000 **Case #:** 7654321000

Primary Care Provider/Clinic Name: Good, Iam A.

Provider/Clinic Phone: (937) 123-4567

Member Services: 1-800-488-0134 (TTY: 1-800-750-0750 or 711)

24-hour Nurse Line: 1-866-206-0554 (TTY: 1-800-750-0750 or 711)

THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT VERIFY ELIGIBILITY.

MEMBER: Show your ID card to medical providers BEFORE you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your primary care provider or call our 24-hour toll-free nurse advice line (see front of card for phone number).

HEALTH CARE PROVIDERS: You must verify member eligibility for the date of service. Visit **CareSource.com** or call **1-800-488-0134** to access this information. Authorization required for inpatient admission.

MAIL MEDICAL CLAIMS TO: CareSource, P.O. Box 8730, Dayton, OH 45401-8730

PHARMACY: Providers call 1-800-488-0134
BENEFITS MANAGER: CVS Caremark
RxBIN 004336 RxPCN ADV RxGRP RX0797

CareSource.com

ALWAYS KEEP YOUR ID CARD(S) WITH YOU

You will need your CareSource ID card each time you get medical services. This means that you need your CareSource ID card when you:

- See your primary care provider (PCP)
- See a specialist or other provider
- Go to an emergency room
- Go to an urgent care facility
- Go to a hospital for any reason
- Get medical supplies
- Get a prescription
- Have medical tests
- Use transportation services

To serve you faster, please have your member ID number on your card whenever you call our Member Services Department.

Call CareSource's Member Services Department as soon as possible if:

- You have not received your card(s) yet
- Any of the information on the card(s) is wrong (If you are changing personal information, such as your phone number, date of birth, or address you will also need to contact your county caseworker.)
- You lose your card(s)
- You have a baby

Your Primary Care Provider

CHOOSING A PRIMARY CARE PROVIDER (PCP)

Each member of CareSource must choose a primary care provider (PCP) from CareSource's Provider Directory. Your PCP is an individual physician, physician group practice, advanced practice nurse or advanced practice nurse group practice trained in family medicine (general practice), internal medicine or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your checkups and shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital.

Sometimes there may be a reason that a specialist may need to be your PCP. If you and/or your specialist believe that they should be your PCP, you should call the Member Services Department to discuss.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource ID card. It is important to try to see your PCP within your first 30 days of enrollment.

The Provider Directory is a list of doctors and other health care providers who accept CareSource members. If you haven't chosen a PCP yet, please choose one from the directory or call us to see if any new PCPs have been added to it recently. It is important that you start to build a good doctor/patient relationship with your PCP as soon as you can. For the names of the PCPs in CareSource, you may look in your Provider Directory if you requested a printed copy, on our website at **CareSource.com**, or you can call the CareSource Member Services Department for help.

If you told the Medicaid Hotline that you did not want a printed provider directory, visit our website at **CareSource.com** to view up-to-date provider panel information.

If you are a new patient to your PCP, please call the office to schedule an appointment. This will help your PCP get to know you and understand your health care needs right away. You should also have all of your past medical records transferred to your new doctor.

CHANGING YOUR PCP

We hope you are happy with the PCP you have chosen, but we know that you may decide to choose a different PCP in the future. If for any reason you want to change your PCP, you must first call the Member Services Department to ask for the change. You can change your PCP as often as once a month, if needed. We will process your change the date of your call. CareSource will send you a new member ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP. The Member Services Department can also help you schedule your first appointment, if needed.

For the names of the PCPs in CareSource, you may look in your Provider Directory if you requested a printed copy, on our website at **CareSource.com**, or you can call the CareSource Member Services Department for help.

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If your PCP tells us that he/she is moving away, retiring or leaving CareSource for any reason, we will assign another PCP for you and let you know by mail within 45 days whenever possible. You can call us if you need help choosing another PCP. We also inform you if any of our participating hospitals within your region stop participating.

PROVIDER DIRECTORY

Our directory is subject to change. Some providers may have been added or removed since it was printed.

If you have a question or want to know which providers participate with CareSource, we can help. Just return your provider directory postcard or visit our website at **CareSource.com**. If you don't have access to our website, you can call our Member Services Department and ask for a copy of our directory.

We can give you the most current information. And we can give you more details about providers when you call, if you want to know more. We want to make sure you are aware of all of your options.

Doctor Appointments

Please schedule appointments with your doctor as far in advance as possible. It is important to keep your scheduled appointments. If you need to cancel or change appointments, please call the doctor's office at least 24 hours in advance. If you miss too many appointments, your doctor may ask that you choose another doctor.

The Ohio Department of Medicaid (ODM) requires that CareSource provide transportation if you must travel 30 miles or more from your home to receive covered health care services. Please refer to your Provider Directory or the CareSource website to determine which providers are affected by this requirement.

When You Can See a Non-Participating Provider

Your Primary Care Provider (PCP) is your personal health provider. For any routine medical needs, contact your PCP first.

It is important to remember that you must receive services covered by CareSource from facilities and/or providers on CareSource's panel. See pages 9-13 for information on services covered by CareSource. The only time you can use providers that are not on CareSource's panel is for:

- Emergency services
- Federally Qualified Health Centers/ Rural Health Clinics
- Certified nurse midwives or certified nurse practitioners
- Qualified family planning providers
- Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health centers and treatment centers
- An out-of-panel provider that CareSource has approved you to see

If you called the Medicaid Hotline to select a managed care plan (MCP), you were asked whether you wanted provider panel information given to you as a printed Provider Directory or via the Internet. If you asked for a printed directory, or did not contact the Medicaid Hotline to enroll and were assigned to our plan, you should have also received a Provider Directory. The Provider Directory lists all of our panel providers as well as other non-panel providers you can use to receive services. If you want to use the Internet, visit our website at **CareSource.com** to view up-to-date provider panel information.

WHEN YOU TRAVEL OUTSIDE OF OUR SERVICE AREA

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

If it's an **emergency**:

- Call 911 or go to the nearest emergency room

If it's **not an emergency**:

- Call your PCP for help for what to do

If you're **not sure if it's an emergency**:

- Call your PCP

  OR

- Call CareSource24, our nurse advice line. The phone number is **1-866-206-0554** (TTY for the hearing impaired: 1-800-750-0750 or 711). We can help you decide what to do.

See page 8 for more information about emergency services and urgent care centers.

In addition, your PCP may decide that you need medical care that you can only get from a doctor or other health care provider who is not participating with CareSource. If your PCP gets prior approval from CareSource for these services, they will be covered.

Preventive Care Is Important

Your PCP will play an important part in your preventive care. This means making regular visits to your doctor even if you do not feel sick. Routine checkups, tests and screenings can help your doctor find and treat problems early before they become serious. Preventive care includes:

- Immunizations for children
- Healthchek exams for children under the age of 21
- Yearly well-adult exams
- Pap smears
- Breast exams
- Regular dental and medical checkups

We have preventive health guidelines for:

- Men
- Women
- Pregnant women
- Babies and children

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

Where to Get Medical Care

We want to make sure you get the right care from the right health care provider when you need it. The following information will help you decide where you should go for medical care:

Is it safe to wait?

How to decide whether to go to an ER, urgent care or PCP

Ask yourself these questions:

- Is it safe to wait and call my doctor first?
- Is it safe to wait and schedule an appointment in the next day or two with my doctor?
- Is it safe to wait if I can get an appointment today with my doctor?
- If my doctor can't see me, is it safe to wait to be seen at an urgent care clinic as a walk-in?
- Could I die or suffer a serious injury if I don't get immediate medical help?

Remember, if you are not sure if your illness or injury is an emergency, call your doctor or call CareSource24, our nurse advice line. Just dial **1-866-206-0554** to talk to a CareSource24 nurse.

PRIMARY CARE SERVICES

You should see your PCP for all routine visits. Some examples of conditions that can be treated by your PCP are:

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

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URGENT CARE CENTERS

You can visit an urgent care center for non-emergency situations to keep an injury or illness from getting worse when your PCP's office is closed or if your PCP is not able to see you right away. If you think you need to go to an urgent care center, you can:

1. Call your PCP for advice. You can reach your PCP, or a back-up doctor, 24 hours a day, 7 days a week.

OR

2. Call CareSource24, our nurse advice line, at **1-866-206-0554** (TTY for the hearing impaired: 1-800-750-0750 or 711).

OR

3. Go to a participating urgent care center listed in your Provider Directory or on our website at **CareSource.com**. After you go, always call your PCP to schedule follow-up care.

Sometimes you get sick or injured while you are traveling. If you think you need to go to an urgent care center while you are away from home and are out of the counties that CareSource covers, call your PCP or CareSource24, our nurse advice line. The number is **1-866-206-0554** (TTY for the hearing impaired: 1-800-750-0750 or 711). They can help you decide what to do. If you go to an urgent care center, call your PCP as soon as you can to let him or her know of your visit.

EMERGENCY SERVICES

Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor. We cover care for emergencies both in and out of the county where you live. Some examples of when emergency services are needed include:

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

You do not have to contact CareSource for an okay 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 primary care provider or the CareSource 24-hour nurse advice line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). Your PCP or the CareSource 24-hour advice line 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 member of CareSource and show them your ID card.
- If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call CareSource.
- If you are able, call your PCP as soon as you can to let him or her know that you have a medical emergency, or have someone call for you. Then call your PCP as soon as you can after the emergency to schedule any follow-up services.
- If the hospital has you stay, please make sure that CareSource is called within 24 hours.

Services Covered By CareSource

As a CareSource member, you will continue to receive all medically necessary Medicaid-covered services at no cost to you. You should not be billed for these services. If you receive a bill, please call us. Services covered by CareSource include the following:

SERVICES THAT DO NOT REQUIRE A REFERRAL

The following services do not require a referral from your PCP. This means that your PCP does not need to arrange or approve these services for you. Just check your Provider Directory for a list of participating providers who offer these services and schedule an appointment yourself. If you are not sure what types of providers offer any of these services, please call CareSource for help.

Primary care provider services	You can make unlimited visits to the participating provider you choose as your PCP.
Yearly well-adult exams	
Well-child (Healthchek) exams for children under the age of 21	
Shots (immunizations)	
Preventive mammogram (breast) and cervical cancer (Pap smear) exams	
Physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source	
Prescription drugs, including certain prescribed over-the-counter drugs	Health care providers will write prescriptions for you that can be filled at a participating pharmacy. Please see the "Prescription Drugs" section of this handbook for more details.
Federally Qualified Health Center or Rural Health Clinic services	
Family planning services and supplies	You may receive services from your PCP or any obstetrician, gynecologist or qualified family planning provider listed in your Provider Directory such as Planned Parenthood.
Obstetrical (maternity care – prenatal and postpartum, including at-risk pregnancy services) and gynecological services	You may go to any participating obstetrician or gynecologist (OB/Gyn) listed in your Provider Directory.
Free-standing birth center services at a free-standing birth center	Please call our Member Services Department at **1-800-488-0134** for available qualified centers.

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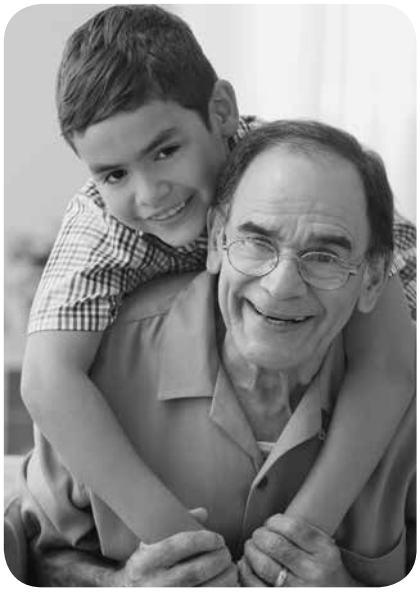
Emergency services	Please see the "Where To Get Medical Care" section on pages 7-8 of this handbook for information on appropriate use of these services.
Mental health and substance abuse services	If you need mental health and/or substance abuse services, please call our Member Services Department. Or you may self-refer directly to an Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health center or treatment center. Please see your Provider Directory, call our Member Services Department, or visit our website at **CareSource.com** for the names and telephone numbers of the facilities near you. You may go to any participating psychologist without a referral. You can make up to 30 visits per year without a referral or prior authorization. You need a referral from your PCP to see a psychiatrist except for those at community mental health centers. Please call us if you have questions.
Vision (optical) services, including eyeglasses	Routine checkups and services from optometrists, as well as eyeglasses, do not require a referral. Other services require a referral from your PCP or optometrist and/or prior authorization from CareSource. You can get glasses and eye exams once every year or once every two years depending on your age: **Members ages 20 or younger:** Eye exams: Once a year Eye glasses: Once a year **Members ages 21-59:** Eye exams: Once every year Eye glasses: Once every two years **Members ages 60 and older:** Eye exams: Once a year Eye glasses: Once a year



Dental services 	Good dental care is an important part of your health. You should visit your dentist for a routine dental exam every six months. These exams help catch problems early. Then you can get proper treatment to help correct any problems before they get worse. CareSource will pay for two dental exams every year. CareSource will also cover the following: • X-rays • Fillings • Simple extractions • Impacted tooth extractions • General anesthesia • Root canals • Healthchek screenings CareSource may also pay for one set of full or partial dentures every eight years with prior authorization. Routine checkups and cleanings do not require a referral. We encourage you to get a checkup every six months. Some services may require a referral from your dentist and/or prior authorization from CareSource. Your dentist will take care of this for you. Please contact the Member Services Department if you have questions about your dental benefit coverage.
Chiropractic (back) services	Members age 21 and older can have up to 15 visits per year without a referral. Members under 21 years of age may have up to 30 visits unless more are medically necessary as part of Healthchek services. Prior authorization may be required.
Podiatry (foot) services	
Speech and hearing services	You can have up to 30 visits per year for speech therapy without a referral or prior authorization. Hearing exams do not require a referral or prior authorization. Prior authorization is required for more than 30 visits.
Screening and counseling for obesity	Services can be obtained from or through your PCP.
Services for children with medical handicaps (Title V)	Services can be obtained from your PCP or from a specialist with a PCP referral.
Medical supplies	These require a prescription. Some supplies require a referral and/or prior authorization.

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Certified nurse midwife services	You may go to a certified nurse midwife (CNM). Check the Provider Directory or call CareSource for the names of available CNMs.
Certified nurse practitioner services	If you would like to see a certified nurse practitioner (CNP), check the Provider Directory or call CareSource for the names of available CNPs.
Non-emergent transportation 	Call CareSource to arrange transportation at: **1-800-488-0134** If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. CareSource also offers additional transportation services. This includes up to 30 one-way trips to medical visits, WIC and redetermination appointments per member per calendar year. Please contact **1-800-488-0134** for assistance at least 48 hours (two business days) before you need a ride. In addition to the transportation assistance that CareSource provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services for questions or assistance with NET services.

SERVICES THAT REQUIRE A REFERRAL

The following services require a referral from your PCP. This means that your PCP will recommend or request these services for you before you can get them. Your PCP will either call and arrange these services for you, give you written approval to take with you when you get the referred services, or just tell you what to do. In some cases, CareSource may authorize a specialist to make referrals for you.

Diagnostic services (X-ray, lab)	Participating specialists may also send you for diagnostic tests. Some may require prior authorization.
Specialist services	This includes visits to participating specialists not listed in the previous section, such as a dermatologist. Participating specialists are listed in the Provider Directory.
Outpatient hospital services	
Physical and occupational therapy	You may have up to 30 visits per year without a prior authorization. Prior authorization is required for services after 30 visits.
Renal dialysis (kidney disease)	

SERVICES THAT REQUIRE A REFERRAL AND PRIOR AUTHORIZATION

The following services require a referral from your PCP *and* prior authorization from CareSource before you can get them. Your PCP will ask for a prior authorization from us then schedule these services for you. If you are seeing a specialist, he/she will get approval from your PCP then your appointment or services will be scheduled.

All inpatient hospital services	Emergency room services do not require a referral or prior authorization. Semi-private room and board is included.
Hospice care (care for terminally ill, e.g., cancer patients)	
Nursing facility services	CareSource covers the stay unless the Ohio Department of Medicaid determines that the member will return to fee-for-service Medicaid. If you need nursing facility services, please call our Member Services Department at **1-800-488-0134** for information on available providers.
Some home health services	All home health aide and private duty nursing services require prior authorization.
Respite services	This is for members under the age of 21 who receive Supplemental Security Income (SSI).
Some durable medical equipment, including hearing aids, customized wheelchairs, contact lenses	
Developmental therapy services for children aged birth to six years	
Orthotics/prosthetics	
Ambulance and ambulette transportation	Emergencies do not require a referral or prior authorization.
Some dental services, including orthodontia	
Some pain management services	
Services from an out-of-network provider	

Please call the CareSource Member Services Department if you have any questions about covered services.

Prescription Drugs

While CareSource covers all medically necessary Medicaid-covered medications, we use a preferred drug list (PDL). These are the drugs that we prefer that your provider prescribe. We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may prior authorize a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first.

Some drugs may also have quantity (amount) limits and some drugs are never covered, such as drugs for weight loss.

If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision and your right to a state hearing.

There are certain medications that are more complex for diseases that require special attention and need to be handled differently than medications you pick up at your local pharmacy. These medications are called “specialty” medications, and most of these drugs require a prior authorization from your doctor.

Many of these medications need to be given to you by a doctor or nurse, and your doctor’s office will help you get that done. If the prior authorization is approved, we will work with your doctor’s office and the specialty pharmacy to get the medications you need.

You can call the Member Services Department to request information on our PDL and medications that require prior authorization. You can also look on our website at **CareSource.com**. Please note that our PDL and list of medications that require prior authorization can change so it is important for you and/or your provider to check this information when you need to fill/refill a medication.

MEDICATION THERAPY MANAGEMENT

At CareSource, we understand the impact that proper medication use can have on your health. That’s why we have a Medication Therapy Management (MTM) program for CareSource members. This program is geared towards helping you learn about your medications and to help make sure the medications that you are taking can be taken together and safely.

This program may be available from your local pharmacists if they are signed up 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 are asking because they want to help you. Through the program, your local pharmacist may get alerts and information about your medications and decide if you may need 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 doctor 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, which also includes anything you take over the counter, and how to use them.

This service and the pharmacist’s help and information are part of being a CareSource member and are available at no cost to you.

MTM Benefits to Providers and Members

- Safer medication choices that will be allowed by your doctor
- Better coordination of care with all your doctors
- More information given to you about your medications
- Another person to help you with your overall health care

Added CareSource Benefits

CareSource also offers extra services and/or benefits to members. These are not available with Ohio Medicaid.

These added CareSource benefits are available at no cost to you. They include:

DENTAL CARE

Good dental care is an important part of your health. You should visit your dentist for a routine dental exam every six months. These exams help catch problems early. Then you can get proper treatment to help correct any problems before they get worse. Ohio Medicaid covers one dental exam every year for members ages 21 and older. For members who are younger than 21, Ohio Medicaid covers two dental exams every year. As a CareSource member, you can receive two dental exams every year.

CARESOURCE24® NURSE ADVICE LINE

CareSource has a 24-hour nurse advice line you can call any time with health or medical questions. Please see page 4 of this handbook for more details.

CARE MANAGEMENT AND OUTREACH SERVICES

CareSource offers care management services that are available to children and adults with special health care needs.

We have registered nurses, social workers and other outreach workers. They can work with you one-on-one to help coordinate your health care needs. These needs may include finding appropriate community resources.

They may contact you if:

- Your doctor requests it
- If you request a phone call
- If our staff feels their services would be helpful to you or your family

CareSource offers care management for conditions that include:

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

CareSource staff may ask you questions to learn more about your health. Our staff will provide you information to help you understand how to care for yourself and access services, including local resources.

Our staff will talk to your PCP and other service providers to make sure you receive coordinated care. You may also have other medical conditions that our case managers can help you with.

Our staff can also work with you if you need help figuring out when to get medical care from your PCP, an urgent care center or the emergency room.

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 reach Care Management Support Services at **1-800-993-6902**.

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HIGH RISK CARE MANAGEMENT

CareSource offers services for members with complex health conditions. A dedicated High Risk Care Management team may work with you one-on-one by telephone and in person to assist you with health education, care coordination, and community resource needs. The High Risk Care Management team will help connect you with your providers and community resources to help you meet your goals for a healthy life by managing your complex health conditions.

HEALTH HOME

A Health Home is an easier way for you to get the care you need from a team of providers. They will work together to meet all your health care needs. When you are enrolled in the Health Home, you'll receive those services instead of our CareSource Care Management services. CareSource Care Management will work with the Health Home to make sure you get your health care goals and needs met.

A Health Home can provide you with:

- A team of doctors and care managers working together with you to coordinate your physical and behavior health care needs
- A dedicated staff to make sure you receive all regular check-ups and health screenings
- Case management services if you need them
- Referrals to community resources that help you get the services you need

CARE TRANSITIONS

CareSource offers a program designed to assist you and/or your family members upon discharge from the hospital.

The goals of the program:

- Answer any questions related to any discharge questions
- Ensure that you and/or your family members understand the medications and be available to answer any questions related to your medications
- To help coordinate your primary care and/or specialist appointments
- To help coordinate you or your family's needs when home

If you or your family member needs assistance with discharge needs from the hospital you can reach a member of the Care Transition team at **1-866-867-0421**.

DISEASE MANAGEMENT

CareSource offers disease management programs. They can help you learn about your health and how you can better manage your specific health conditions. These programs are available to you at no cost.

We have programs for:

- Asthma
- Diabetes

Goals of our programs include:

- Helping you understand how to take good care of yourself
- Helping you adopt a healthy lifestyle. If you need help to stop smoking, a case manager can assist you
- Working with your doctor to reach your health goals

CareSource automatically enrolls members with these conditions into the Disease Management program. If you do not want to be in this program, please call **1-888-882-3614**.

BABIES FIRST PROGRAM

If you are pregnant, you can earn special rewards by receiving prenatal care for you and preventive care for your baby. Call our Member Services Department or sign up on **CareSource.com** to join the program.

TRANSPORTATION

If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. Please call **1-800-488-0134** to arrange a ride at least 48 hours (two business days) before your appointment.

CareSource also offers additional transportation services, if needed. We cover up to 30 one-way trips per member per calendar year to any health care, WIC or redetermination appointments. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room.

CARESOURCE TRANSPORTATION POLICY

Please review the following information carefully to understand your responsibilities. These rules have been made to help ensure your safety and to avoid transportation delays.

Member Transportation Responsibilities

1. Members are expected to:
    - Call to arrange non-emergent transportation 48 hours (two business days) in advance. *Saturday, Sunday, and holidays do not count.*
    - Have the complete address of the health care provider's office that you are going to.
    - Be at your pick-up address at least 90 minutes before your appointment time. This will ensure that the driver has adequate travel time so you are not late for your appointment.
    - Show your ID card to the driver before using transportation services.
    - Be ready when the driver gets there for curbside pick-up and drop-off services. The driver can wait for only five minutes. *After five minutes, he/she will leave and this will count against you as a "no-show".*
    - If you can't make it, please call to cancel transportation at least two hours before your scheduled pick-up time. Ask the provider's office to call the transportation company for your return trip home.
    - If you need to have a prescription filled at the provider's facility before leaving, please do so before requesting the return-trip call.
2. Members who are not ready and waiting cause no-show transportation charges for attempting to pick you up for your appointment. The transportation company reserves the right to take away your transportation benefit for six months after three no-shows within three months. A no-show is defined as:
    - Not being at the pick-up address at least 90 minutes before your appointment time.
    - The driver waits five minutes and leaves.
    - Not calling to cancel at least one hour before the scheduled pick-up time.
3. Members are expected to be courteous and show respect to the transportation company and CareSource staff. Improper, discourteous behavior may result in a 6-month suspension of transportation benefits for the family. Improper behavior includes:
    - Use of profanity (swearing), name-calling, or verbal abuse
    - Threats of physical abuse to the transportation company, drivers, or CareSource staff

CareSource and the transportation company reserve the right to immediately discontinue transportation services to members who violate these guidelines or misuse or abuse the transportation benefit.

Please keep this policy in mind. We want your transportation experiences to be positive. Please call the Member Services Department if you have any questions or concerns.

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

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EYEGLASSES

You can choose from a large selection of certain stylish eyeglass frames, including wire-rim frames. These frames are available, in addition to those approved by Ohio Medicaid, at no cost to you. Ask your vision care provider to show you which frames are available to you. See page 10 for more information about your vision benefits.

HEALTH INFORMATION

Preventive medical and dental care is an important part of keeping you and your family healthy. Regular care helps your primary care provider find problems early so they can be treated before they get worse.

Knowing how to lead a healthy lifestyle also helps you to stay well. CareSource offers information about well-child care, immunizations, family planning and health and safety through our many brochures and member newsletters. You may receive health information:

- Through the mail
- From our website at **CareSource.com**
- By calling us at **1-800-488-0134** to request it

Healthchek

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21 years. These exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at the following ages:

- Birth
- 3-5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- After that, children should have at least one exam per year.

Healthchek also covers complete medical, vision, dental, hearing, nutritional, developmental, and mental health exams, in addition to other care to treat physical, mental, or other problems or conditions found by an exam.

Healthchek covers tests and treatment services that may not be covered for people over age 20; some of the tests and treatment services may require prior authorization.

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

- Preventive checkups for newborns, infants, children, teens and young adults under the age of 21
- Healthchek screenings:
  - Complete medical exams (with a review of physical and mental health development)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing

- Laboratory tests for certain ages
- Immunizations
- Medically necessary follow-up care to treat physical, mental, or other health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - Visits with a primary care provider, specialist, dentist, optometrist and other CareSource providers to diagnose and treat problems or issues
  - Inpatient or outpatient hospital care
  - Clinic visits
  - Prescription drugs
  - Laboratory tests
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for

treatment, before the problem gets more serious. Some services may require a referral from your PCP or prior authorization by CareSource. Also, for some EPSDT items or services, your provider may request prior authorization for CareSource to cover things that have limits or are not covered for members over age 20. Please see pages 12-13 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 years who have special health care needs. Please see page 15 to learn more about the care management services offered by CareSource.

Call your PCP to schedule an appointment for a Healthchek exam. Make sure to ask for a Healthchek exam when you call your PCP. CareSource asks that you schedule exams for all eligible family members regularly. You should try to schedule the first exam within 90 days of becoming a member. If you would like more information on the Healthchek program, please contact our Member Services Department. We can help you:

- Access care
- Find a provider
- Make an appointment
- Find out what services are covered and which ones may need prior authorization
- Arrange transportation, if needed

COORDINATED SERVICES PROGRAM (CSP)

Consumers eligible for Ohio Medicaid may be selected for enrollment in the Coordinated Services Program (CSP). The program coordinates treatment for members who have high patterns of utilization of both medications and services.

Except in pharmacy emergencies, CSP enrollees:

- Must choose one pharmacy to fill their prescriptions
- Are encouraged to see one PCP who will coordinate care with other providers

Enrollees can change their pharmacy or PCP under limited circumstances. Members selected for the CSP will be notified in writing, provided additional information, and notified of their state hearing rights.

Services Not Covered By CareSource or Ohio Medicaid

CareSource will not pay for services or supplies received without following the directions in this handbook. CareSource will not pay for the following services that are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Acupuncture and biofeedback services
- All services or supplies that are not medically necessary
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Inpatient treatment to stop using drugs and/or alcohol (inpatient detoxification services in a general hospital are covered)
- Paternity testing
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary

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- Services to find cause of death (autopsy) or services related to forensic studies
- Services determined by Medicare or another third-party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Medications that are being used for erectile dysfunction, weight loss, infertility or cosmetic purposes

This is not a complete list of the services that are not covered by Medicaid or CareSource. If you have a question about whether a service is covered, please call the Member Services Department.

Medicaid Eligibility and Other Health Insurance

ACCIDENTAL INJURY OR ILLNESS (SUBROGATION)

If a CareSource member has to see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services Department at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711) to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay the doctor's and/or hospital's bill. When you call we will need the name of the person at fault, their insurance company and the name(s) of any attorneys involved.

OTHER HEALTH INSURANCE (COORDINATION OF BENEFITS – COB)

If you have health insurance with another company, it is very important that you call the Member Services Department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent then you need to call the Member Services Department to give us the information. It is also important to call the Member Services Department and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

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

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

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

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

LOSS OF INSURANCE NOTICE (CERTIFICATE OF CREDITABLE COVERAGE)

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

LOSS OF MEDICAID ELIGIBILITY

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this would happen, CareSource would be told to stop your membership as a Medicaid member and you would no longer be covered by CareSource. If you have questions about your eligibility, please contact your county caseworker.

Transportation can be provided for your redetermination appointment, if needed. Please see pages 12 and 17 in this handbook or call our Member Services Department for more details.

AUTOMATIC RENEWAL OF MCP MEMBERSHIP

If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically become a CareSource member again.

AUTOMATICALLY RENEWED MEMBERS

Members who have not selected a managed care plan (MCP) will be automatically assigned to an MCP by the enrollment broker. If you are a member who is automatically reenrolled into our plan, you will be sent a complete new member kit.

Your Membership Rights

As a member of CareSource you have the following rights:

- To receive information about CareSource, our services, our practitioners and providers and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally okayed to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask for, and get, a copy of your medical records, and to be able to ask that the record be changed/ corrected if needed.
- To be able to say yes or no to having any information about you given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or CareSource must talk to you about what could happen and they must put a note in your medical record about it.
- To be able to file an appeal, a grievance (complaint) or state hearing. See pages 26-29 of this handbook for information.
- A right to voice complaints or appeals about the organization or the care it provides.
- To be able to get all CareSource written member information from CareSource:
  - At no cost to you.
  - In the prevalent non-English languages of members in CareSource's service area.
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from CareSource and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See pages 34-37 which explain about advance directives. You can also contact the Member Services Department for more information.

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- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on CareSource's panel at least monthly. CareSource must send you something in writing that says who the new PCP is and the date the change began.
- To be free to carry out your rights and know that CareSource, CareSource's providers or the Ohio Department of Medicaid (ODM) will not hold this against you.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, to be able to go to a woman's health provider on CareSource's panel for covered woman's health services.
- To be able to get a second opinion from a qualified provider on CareSource's panel. If a qualified provider is not able to see you, CareSource must set up a visit with a provider not on our panel.
- If CareSource is unable to provide a necessary and covered service in our network, CareSource will cover these services out of network for as long as we are unable to provide the service in network. If you are approved to go out of network, this is your right as a member and will be provided at no cost to you.
- To get information about CareSource from us.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services' Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601

(312) 886-2359
TTY: (312) 353-5693

Bureau of Civil Rights
Ohio Department of Job and Family Services
30 E. Broad St., 30th Floor
Columbus, Ohio 43215

(614) 644-2703 1-866-227-6353
TTY: 1-866-221-6700
Fax: (614) 752-6381

CareSource may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.

CARESOURCE NOTICE OF PRIVACY PRACTICES

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

Your Rights

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

Get a copy of your health and claims records

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

Ask us to fix health and claims records

- You can ask us to fix your health and claims records

if you think they are wrong or not complete. Ask us how to do this.

- We may say "no" to your request. If we do we will tell you why in writing within 60 days.

Ask for private communications

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

Ask us to limit what we use or share

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

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

- You can ask for a list (accounting) of the times we've shared your health information. This is limited to six years before the date you ask. You may ask who we shared it with, and why.
- We will include all the disclosures except for those about:
  - care,
  - 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 within 12 months, we will charge a fair, cost-based fee.

Get a copy of this privacy notice

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

Give CareSource consent to speak to someone on your behalf

- You can give CareSource consent to talk about your health information with someone else on your behalf.
- If you have a legal guardian, that person can use your rights and make choices about your health information. CareSource will give out health information to your legal guardian. We will make sure a legal guardian has this right and can act for you 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 go ahead and 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.

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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

Other Uses and Disclosures

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

Help you get health care treatment

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

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.

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.

To run our business

- We may use or share your health information to run our business.

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.

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.

Special Rules for CareSource Members in Ohio: Ohio law requires that we get your approval in many cases before:

- giving out the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition;
- giving out information about drug and alcohol treatment you may have received in a drug and alcohol treatment program;
- giving out information about mental health care you may have received; and
- giving out certain information to Ohio's long-term care investigators.

For full information on when such approval may be needed, you can contact the CareSource Privacy Officer.

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 notice was effective April 14, 2003 and this version was effective September 1, 2014. 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: 1-800-488-0134, ext. 2023

Member Responsibilities

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

- Use only approved providers.
- Keep scheduled doctor appointments, be on time, and if you have to cancel, call 24 hours in advance.
- Follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your ID card and present it when receiving services.

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- Never let anyone else use your ID card.
- Notify your county caseworker and CareSource of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and your county caseworker know if any member of your family has other health insurance coverage.
- Provide the information that CareSource and your health care providers need, to the extent possible, in order to provide care for you.
- Understand as much as possible about your health issues and take part in reaching goals that you and your health care provider agree upon.

Consult our website (**CareSource.com**) or newsletters annually for any updates to member rights and responsibilities.

Fraud, Waste and Abuse

CareSource has a program designed to handle cases of managed care fraud. Fraud can be committed by providers or members. 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 your CareSource ID card with another person
- Selling prescribed drugs or other medical equipment paid for by CareSource to others
- Forging a doctor's signature on Babies First coupons, prescriptions, etc.
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

IF YOU SUSPECT FRAUD, WASTE OR ABUSE

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

- Calling us at **1-800-488-0134** (TTY for the hearing impaired: 1-800-750-0750 or 711)
- 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: Special Investigations Unit
  P.O. Box 1940
  Dayton, OH 45402

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, 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.

How to Let CareSource Know If You Are Unhappy or Do Not Agree With a Decision We Made

We hope you will be happy with CareSource and the service we provide. If you are unhappy with anything about CareSource or its providers you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know this. CareSource wants you to contact us so that we can help you. To contact us, you can:

- Call the Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711), *OR*

- Fill out the form in your Member Handbook, *OR*
- Call the Member Services Department to request they mail you a form, *OR*
- Visit our website at **CareSource.com**, *OR*
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your CareSource member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

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

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

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

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

- Make a decision on whether to okay a request to cover a service for you, *OR*
- Give you an answer to something you told us you were unhappy about.

If you do not agree with the decision/action listed in the letter, and you contact us within 90 calendar days to ask that we change our decision/action, this is called an **appeal**. The 90 calendar day period begins on the day after the mailing date on the letter. Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we have made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services. You can also appeal by phone or in writing. You can submit information to help explain your case if you want.

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

- Two working days for grievances about not being able to get medical care
- 30 calendar days for all other grievances except grievances that are about getting a bill for care you have received
- 60 calendar days for grievances about getting a bill for care you have received

If your grievance is about getting a bill for care you or a family member received, please call the telephone number on the bill to make sure they have your CareSource ID number, or to give them the primary insurance for the family member who received the care. If they tell you they have this information, please ask them why you are receiving a bill.

After you have done this, please contact our Member Services Department and provide us with the following information contained on your bill:

- The date you or your family member received services
- The amount of the bill
- The provider's name
- The telephone number
- The account number
- Tell us why the provider's office told you they were billing you

If you are not happy with our answer to your grievance, please contact our Member Services Department and we will be happy to discuss it with you.

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

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

1-800-605-3040 or **1-800-324-8680**
(TTY: 1-800-292-3572)

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Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215

1-800-686-1526

STATE HEARINGS

CareSource will notify you of your right to request a state hearing when:

- A decision is made to deny services
- A decision is made to reduce, suspend, or stop services before all of the approved services are received
- A provider is billing you because CareSource has denied payment of the service
- A decision is made to propose enrollment or continue enrollment in the Coordinated Services Program (CSP)
- A decision is made to deny your request to change your Coordinated Services Program (CSP) provider

At the time CareSource makes the decision, or is aware that the provider is billing you for payment, we will mail you a state hearing form. If you want a state hearing, you must request a hearing within 90 calendar days. The 90 calendar day period begins on the day after the mailing date on the hearing form. If we have made a decision to reduce, suspend, or stop services before all of the approved services are received and you request the hearing within 15 calendar days from the mailing date on the form, we will not take the action until all approved services are received or until the hearing is decided, whichever date comes first. You may have to pay for services you receive after the proposed date to reduce, suspend, or stop services if the hearing officer agrees with our decision. If we propose to enroll you in the Pharmacy Controlled Substance Program and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

To request a hearing you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at **1-866-635-3748**, or submit your request via email at **bsh@jfs.ohio.gov**. A state hearing is a meeting with you, someone from the County Department of Job and Family Services, someone from CareSource and a hearing officer from Ohio Department of Job and Family Services (ODJFS). CareSource will explain why we made our decision and you will tell why you think we made the wrong decision. The hearing officer will listen and then decide who is right based upon the information given and whether we followed the rules. If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at **1-800-589-5888** for the local number.

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

EXTERNAL REVIEW

In addition to a state hearing, you may ask for an independent review if CareSource decides not to approve medical care that has been requested for you. This is done by a certified medical review company. It is not done by CareSource. You must go through CareSource's appeal process first and ask for one within 45 days of getting our answer to your appeal.

To ask for one, please write to us at:
CareSource
Attn: Independent Review – QI Dept.
P.O. Box 8738
Dayton, OH 45401-8738

Or you can call the Member Services Department to request it. Your case may be urgent. If so, you will get an answer within 72 hours of asking for the review. If it is not urgent, you will get an answer in 30 days.

MEMBER GRIEVANCE/APPEAL FORM **OHIO**

Member Name _____ Member Address _____ _____	Member ID # _____ Member Telephone (_____)_____

If the grievance/appeal concerns a provider(s), please supply the following information, if known:

Name of Provider(s) _____

Address _____

Telephone (_____) _____

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

_____ _____
(Member Signature) (Date Filed)

OFFICE USE ONLY Date Received: Received By: Grievance Level 1 2 Hearing Date:	Action taken to resolve grievance/appeal: _____ _____ (Signature Plan Rep) (Resolution Date)

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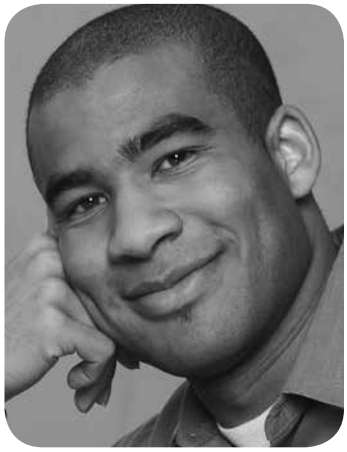
Membership Terminations

We hope you will be happy with CareSource and discuss with us any problems or concerns you may have so we can try to resolve them.

ENDING YOUR MCP MEMBERSHIP



As a member of a managed care plan, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month for your area. The Ohio Department of Medicaid will send you something in the mail to let you know when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment month for your area you can call the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572). You can also submit a request online to the Medicaid Hotline website at **www.ohiomh.com**. Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

CHOOSING A NEW PLAN

If you are thinking about ending your membership to change to another health plan, you should learn about your choices, especially if you want to keep your current doctor(s). Remember, each health plan has its own list of doctors and hospitals that they will allow you to use. Each health plan also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a health plan you are thinking of joining or if you simply would like to ask questions about the health plan, you may either call the plan or call the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572). You can also find information about the health plans in your area by visiting the Medicaid Hotline website at **www.ohiomh.com**.

JUST CAUSE MEMBERSHIP TERMINATIONS

Sometimes there may be a special reason that you need to end your health plan membership. This is called a "Just Cause" membership termination. Before you can ask for a just cause membership termination you must first call your managed care plan and give them a chance to resolve the issue. If they cannot resolve the issue, you can ask for a Just Cause termination at any time if you have one of the following reasons:

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

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You may ask to end your membership for Just Cause by calling the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572). The Ohio Department of Medicaid (ODM) will review your request to end your membership for Just Cause and decide if you meet a Just Cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your Just Cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

THINGS TO KEEP IN MIND IF YOU END YOUR MEMBERSHIP

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

- Continue to use CareSource doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new health plan and have not received a member ID card before the first day of the month when you are a member of the new plan, call the plan's Member Services Department. If they are unable to help you, call the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572).
- If you were allowed to return to the regular Medicaid program and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new health plan and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or X-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

OPTIONAL MEMBERSHIP TERMINATIONS

Children under nineteen (19) years of age have the option to choose not to be a member of a managed care plan if they are:

- Receiving foster care or adoption assistance under Title IV-E,
- In foster care or other out-of-home placement, *OR*
- Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH).

Additionally, if anyone is a member of a federally recognized Indian tribe, regardless of age, they have the option to not be a member of a managed care plan.

If you believe that you/your child meet any of the above criteria and do not want to be a member of a managed care plan, you can call the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572). If someone meets the above criteria and does not want to be an MCP member, his/her membership will be ended.

EXCLUSIONS — INDIVIDUALS WHO ARE NOT PERMITTED TO JOIN A MEDICAID MCP

- Dually eligible under both the Medicaid and Medicare programs,
- Institutionalized (in a nursing home, long-term care facility, ICF-MR, or some other kind of institution),
- Eligible for Medicaid by spending down their income or resources to a level that meets the Medicaid program's financial eligibility requirements,
- Receiving Medicaid Waiver services, *OR*
- Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH) for a diagnosis of cancer, cystic fibrosis or hemophilia.

If you believe that you meet any of the above criteria and should not be a member of a managed care plan, you must call the Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572). If you meet the above criteria, your MCP membership will be ended.

CAN CARESOURCE END MY MEMBERSHIP?

CareSource may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio

Department of Medicaid must okay the request before your membership can be ended. The reasons that CareSource can ask to end your membership are:

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

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

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

1-800-324-8680
TTY: 1-800-292-3572

You can also visit the Ohio Department of Medicaid on the web at **www.medicaid.ohio.gov**.

Quality Health Care

We want to make sure that you receive quality health care. We do this by:

- Reviewing the care you receive from your doctors and other health care providers
- Finding and correcting any problems related to proper medical care
- Making sure care is available to you when you need it
- Providing health education information to you and your providers

REVIEW OF HEALTH CARE SERVICES

CareSource keeps track of the services you get from health care providers. We discuss some services with your providers before you get them to make sure they are appropriate and necessary. For example, we review surgeries or stays at a hospital (unless they are emergencies). This is called utilization management. It makes sure you get the right amount of care you need when you need it.

All utilization management determinations are made by qualified Physician Reviewers. CareSource monitors the work of our reviewers on an ongoing basis. Part of the monitoring includes testing reviewers by presenting each of them with the same cases to ensure they make consistent and objective determinations.

CareSource determines if a service can be covered or not within 14 calendar days. This can be done quicker if the member's medical condition warrants it. We notify your doctor in writing of the determination and the reason for it. If we are not able to cover the service, we notify you in writing, too. The letter includes our phone number in case you want to call us for more information. If you are not happy with the determination, you can appeal it by calling or writing to CareSource. Your case will be re-reviewed by a different doctor from an appropriate specialty area, and you will be notified of the determination in writing.

You can contact us at any time about utilization management or prior authorization requests. Just call the Member Services Department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). You can also send us an email at any time through our website. Just visit **CareSource.com**. Staff are identified by name, title and organization name when initiating or returning calls regarding utilization management issues.

Any decisions we make with your providers about the medical necessity of your health care are based only on how appropriate the care setting or services are. CareSource does not reward providers or our own staff for denying coverage or services. We do not offer financial incentives to our staff that encourage them to make decisions that result in underutilization.

CareSource may decide that a new development not currently covered by Medicaid will be a covered benefit. This includes newly developed:

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

Coverage is based on:

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

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You can contact CareSource to get any other information you want including the structure and operation of CareSource and how we pay our providers. You can also find out about:

- How we work with other health plans if you have other coverage
- Results of member surveys
- How many members disenroll from CareSource
- Benefits, eligibility, claims or participating providers

If you want to tell us about things you think we should change, please call the Member Services Department. Our members' health is always our top priority.

Advance Directives

USING ADVANCE DIRECTIVES TO STATE YOUR WISHES ABOUT YOUR MEDICAL CARE

Many people today worry about the medical care they would get if they became too sick to make their wishes known.

Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

YOU HAVE A CHOICE

A growing number of people are acting to make their wishes known. You can state your medical care wishes in writing while you are healthy and able to choose.

Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

This information explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care.

This information also explains how you can state your wishes about the care you would want if you could not choose for yourself.

This information does not contain legal advice, but will help you understand your rights under the law.

For legal advice, you may want to talk to a lawyer. For information about free legal services, call **1-800-589-5888**, Monday through Friday, 8:30 a.m. to 5 p.m.

WHAT ARE MY RIGHTS TO CHOOSE MY MEDICAL CARE?

You have the right to choose your own medical care. If you don't want a certain type of care, you have the right to tell your doctor you don't want it.

WHAT IF I'M TOO SICK TO DECIDE? WHAT IF I CAN'T MAKE MY WISHES KNOWN?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you're able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

WHAT KINDS OF FORMS ARE THERE?

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, a Durable Power of Attorney for medical care or a Do Not Resuscitate (DNR) Order.

You fill out an advance directive while you're able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

DO I HAVE TO FILL OUT AN ADVANCE DIRECTIVE BEFORE I GET MEDICAL CARE?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

WHO CAN FILL OUT AN ADVANCE DIRECTIVE?

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

DO I NEED A LAWYER?

No, you don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

DO THE PEOPLE GIVING ME MEDICAL CARE HAVE TO FOLLOW MY WISHES?

Yes, if your wishes follow state law. However, Ohio law includes a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

LIVING WILL

This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your wishes known. You can state when you would or would not want food and water supplied artificially.

HOW DOES A LIVING WILL WORK?

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- In a coma that is not expected to end, *OR*
- Beyond medical help with no hope of getting better and can't make your wishes known, *OR*
- Expected to die and can't make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes.

Only you can change or cancel your Living Will. You can do so at any time.

DO NOT RESUSCITATE ORDER

State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identifies a person and specifies that CPR should not be administered to the person so identified. CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR.

The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a patient with a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken.

You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.

DURABLE POWER OF ATTORNEY

A Durable Power of Attorney for medical care is different from other types of powers of attorney. This information is only about a Durable Power of Attorney for medical care, not about other types of powers of attorney.

A Durable Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while.

WHO SHOULD I CHOOSE?

You can choose any adult relative or friend whom you trust to act for you when you can't act for yourself. Be sure to talk with the person about what you want. Then write down what you do or don't want on your form. You should also talk to your doctor about what you want. The person you choose must follow your wishes.

When does my Durable Power of Attorney for medical care take effect?

The form takes effect only when you can't choose your care for yourself, whether for a short or long while.

The form allows your relative or friend to stop life support only in the following circumstances:

- If you are in a coma that is not expected to end, *OR*
- If you are expected to die.

DECLARATION FOR MENTAL HEALTH TREATMENT

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

The Declaration for Mental Health Treatment supersedes a Durable Power of Attorney for mental health care, but does not supersede a Living Will.

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WHAT IS THE DIFFERENCE BETWEEN A DURABLE POWER OF ATTORNEY FOR MEDICAL CARE AND A LIVING WILL?

Your Living Will explains, in writing, the type of medical care you would want if you couldn't make your wishes known.

Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.

IF I HAVE A DURABLE POWER OF ATTORNEY FOR MEDICAL CARE, DO I NEED A LIVING WILL, TOO?

You may want both. Each addresses different parts of your medical care.

A Living Will makes your wishes known directly to your doctors, but states only your wishes about the use of life-support methods.

A Durable Power of Attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can't act for yourself. A Durable Power of Attorney for medical care does not supersede a Living Will.

CAN I CHANGE MY ADVANCE DIRECTIVE?

Yes, you can change your advance directive whenever you want.

If you already have an advance directive, make sure it follows Ohio's law (effective October 10, 1991). You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

IF I DON'T HAVE AN ADVANCE DIRECTIVE, WHO CHOOSES MY MEDICAL CARE WHEN I CAN'T?

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months. Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also.

OTHER MATTERS TO THINK ABOUT

WHAT ABOUT STOPPING OR NOT USING ARTIFICIALLY SUPPLIED FOOD AND WATER?

Artificially supplied food and water means nutrition supplied by way of tubes placed inside you. Whether you can decide to stop or not use these depends on your state of health.

- If you are expected to die and can't make your wishes known, and your Living Will simply states you don't want life-support methods used to lengthen your life, then artificially supplied food and water can be stopped or not used.
- If you are expected to die and can't make your wishes known, and you don't have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.
- If you are in a coma that is not expected to end, and your Living Will states you don't want artificially supplied food and water, then artificially supplied food and water may be stopped or not used.
- If you are in a coma that is not expected to end, and you don't have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water. However, he or she must wait 12 months and get approval from a probate court.

BY FILLING OUT AN ADVANCE DIRECTIVE, AM I TAKING PART IN EUTHANASIA OR ASSISTED SUICIDE?

No, Ohio law doesn't allow euthanasia or assisted suicide.

WHERE DO I GET ADVANCE DIRECTIVE FORMS?

Many of the people and places that give you medical care have advance directive forms. Ask the person who gave you this information for an advance directive form — either a Living Will, a Durable Power of Attorney for medical care, a DNR Order, or a Declaration for Mental Health Treatment. A lawyer could also help you.

WHAT DO I DO WITH MY FORMS AFTER FILLING THEM OUT?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Durable Power of Attorney for medical care, give that person a copy.

Put a copy with your personal papers. You may want to give one to your lawyer or clergy person.

Be sure to tell your family or friends about what you have done. Don't just put these forms away and forget about them.

ORGAN AND TISSUE DONATION

Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State ID Card, or
2. You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

This information is endorsed by the following organizations:

Association of Ohio Philanthropic Homes and Housing for the Aging

Office of the Attorney General, State of Ohio

Ohio Academy of Nursing Homes

Ohio Council for Home Care

Ohio Department of Aging

Ohio Department of Health

Ohio Department of Job and Family Services

Ohio Department of Mental Health and Addiction Services (MHA)

Ohio Health Care Association

Ohio Hospice Organization

Ohio Hospital Association

Ohio State Bar Association

Ohio State Medical Association

Office of Communications

JFS 08095 (Rev. 10/2009)

Equal Opportunity Employer

CareSource™

Word Meanings

Advance Directives Or Living Will — Documents you sign in case you become seriously ill to let your doctor and others know your wishes concerning medical treatment. You sign them while you are still healthy and able to make such decisions.

Benefits — Health care services that are covered by CareSource.

Grievance — A complaint about CareSource or its health care providers.

Member — An eligible Medicaid recipient who has joined CareSource and receives health care services from participating providers.

Non-Participating Provider — A doctor, hospital, pharmacy or other licensed health care professional who has not signed a contract agreeing to provide services to CareSource members. Please see "When You Can See a Non-Participating Provider" on page 6 of this handbook.

Participating Provider — A doctor, hospital, pharmacy or other licensed health care professional who has signed a contract agreeing to provide services to CareSource members. They are listed in our Provider Directory.

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

Prior Authorization — Sometimes participating providers contact CareSource about the care they want you to get. This is done before you get the care to make sure it is the best care for your needs and that it will be covered. It is needed for some services that are not routine, such as home health care or some scheduled surgeries.

Provider Directory — A list of the doctors and other health care providers you can go to as a CareSource member.

Provider Panel — A complete listing of all health care providers actively participating with CareSource from which the **Provider Directory** is created.

Referral — A request from a PCP for his or her patient to see a specialist, such as a surgeon, for care.

Service Area — The geographical locations in Ohio where CareSource is an option as a managed care provider for Medicaid members.

Specialist — A doctor who focuses on a particular kind of health care such as a surgeon or a cardiologist (heart doctor).

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