2025 Member Handbook

Ohio Medicaid

CareSource®

Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call **1-800-488-0134** (TTY: 711).

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad. Llame al **1-800-488-0134** (TTY: 711).

Jwenn èd gratis nan lang ou ak entèprèt ak lòt materyèl ki ekri. Jwenn èd ak sipò gratis si ou gen yon andikap. Rele **1-800-488-0134** (TTY: 711).

Отримайте безкоштовну допомогу своєю мовою з перекладачами та іншими письмовими матеріалами. Отримайте безкоштовні засоби допомоги та підтримку, якщо Ви є особою з інвалідністю. Телефонуйте за номером **1-800-488-0134** (Для осіб з вадами слуху TTY: 711).

तपाईंकै भाषामा दोभाषे तथा अन्य लिखित सामग्रीहरू निःशुल्क प्राप्त गर्नुहोस्। तपाईंसँग असक्षमता छ भने निःशुल्क सहायताहरू तथा समर्थन प्राप्त गर्नुहोस्। **1-800-488-0134** (TTY: 711) मा फोन गर्नुहोस्।

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. احصل على مساعدات مجانية ودعم مجاني إذا كنت تعاني من إعاقة. اتصل على الرقم **1-800-488-0134**(TTY "الهاتف النصي للصم وضعاف السمع": 711).

Ka hel caawimo bilaash ah luqadaada leh turjubaano iyo agab kale oo qoran. Hel gargaar iyo taageero bilaash ah haddii aad naafo tahay Wac **1-800-488-0134** (TTY: 711).

Получите бесплатную помощь на своём языке с переводчиками и другими письменными материалами. Получите бесплатные вспомогательные средства и поддержку, если Вы являетесь лицом с инвалидностью. Звоните по номеру **1-800-488-0134** (Для лиц с нарушениями слуха TTY: 711).

Pata msaada wa bure katika lugha yako pamoja na wakalimani na maandishi mengine. Pata usaidizi na msaada bila malipo kama una ulemavu. Piga simu **1-800-488-0134** (TTY: 711). Obtenez gratuitement de l’aide dans votre langue au moyen d’interprètes et de documentation écrite. Obtenez des aides et un soutien gratuits si vous avez un handicap. Appelez le **1-800-488-0134** (ATS : 711).

Habwa ubufasha mu rurimi rwawe kubuntu ubifashijwemo n'abasemuzi hamwe n'inyandiko. Habwa ubufasha n'inkunga ku buntu nimba ufite ubumuga. Call **1-800-488-0134** (TTY: 711). Og‘zaki tarjimonlar va boshqa yozma materiallar orqali o‘z ona tilingizda bepul yordam oling. Agar nogironligingiz bo‘lsa, bepul yordam va ko‘mak oling. **1-800-488-0134** (TTY: 711) raqamiga qo‘ng‘iroq qiling.

د شفاهي ژباړونکو او نورو لیکل شویو موادو له لاري په خپله ژبه کې وړیا مرسته ترلاسه کړئ. وړیا مرستي او ملاتړ ترلاسه کړئ که تاسو معلولیت لرئ. **1-800-488-0134** (TTY: 711) ته زنګ ووهئ.

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị qua thông dịch viên và các tài liệu dạng văn bản khác. Nhận hỗ trợ và trợ giúp miễn phí nếu quý vị là người khuyết tật. Gọi số **1-800-488-0134** (TTY: 711).

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برای دریافت کمک رایگان به زبان خود با مترجمان و دیگر مواد کتبی تماس بگیرید. برای دریافت کمک‌ها و حمایت رایگان در صورت داشتن معلولیت اقدام کنید. به این شماره ها تماس بگیرید**1-800-488-0134** (تلفن ارتباط برای ناشنوایان: 711).

We follow all state and federal civil rights laws. We do not discriminate, exclude, or treat people differently based on race, color, national origin, disability, age, religion, sex (which includes pregnancy, gender, gender identity, sexual preference, and sexual orientation), or based on marital, health, or public assistance status. We want all people to have a fair and just chance to be as healthy as they can be.

We offer free aids, services, and reasonable modifications if you have a disability. We can get a sign language interpreter. This helps you talk with us or to your providers. Get your printed materials in large print, audio, or braille at no cost. We can also help if you speak a language other than English. We can get an interpreter who speaks your language. Or get printed materials in your language. You can get this all at no cost to you. Call 1-800-488-0134 (TTY: 711) if you need any of this help. We are open Monday through Friday, 7 a.m. to 8 p.m. We are here for you.

You may file a grievance if we did not provide these services to you or if you think we discriminated in any other way.

Mail: CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947
Dayton, OH 45401

Phone: 1-844-539-1732 (TTY: 711)
Fax: 1-844-417-6254
Email: CivilRightsCoordinator@CareSource.com

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

Mail: U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Mail the complaint form found at
www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

Online: https://ocrportal.hhs.gov

You can find this notice at **CareSource.com**.

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Welcome!

CareSource is proudly based in Ohio. That means we live and work in the same communities as our members. Your health and well-being are personal to us. We are a not-for-profit health plan that has been here since the beginning and will serve you through the next generation. Our focus has always been and will always be you.

Welcome to CareSource. You are now a member of a health care plan, also known as a managed care organization (MCO). CareSource provides health care services to Ohio residents who are eligible, including individuals with low income, individuals who are pregnant, infants, children, older adults, and individuals with disabilities.

CareSource may not discriminate on the basis of age, gender, gender identity, sexual orientation, race, color, religion, national origin, military status, veteran status, ancestry, disability, genetic information, health status, or the need for health services.

It is important to remember that you must receive services covered by CareSource from facilities and providers in CareSource's network. Providers in the CareSource network agree to work with your health plan to give you needed care. The only time you can use providers that are not in CareSource's network is for:

- emergency services,
- federally qualified health centers (FQHC)/rural health clinics (RHC),
- qualified family planning providers,
- an out of network provider that CareSource has approved you to see

The Provider Directory lists all our network providers you can use to receive services. You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your member identification (ID) card. You can also visit our website at **findadoctor.CareSource.com** to view up to date provider network information or call Member Services at **1-800-488-0134** (TTY: 711) Monday through Friday from 7 a.m. to 8 p.m. for help. You can view provider information like their name, address, telephone numbers, professional qualifications, specialty, medical school attended, residency completion, board certification status and more on our website.

CareSource®

CONTACT US

Member Services

Phone:	**1-800-488-0134** (TTY: 711) Open Monday through Friday, 7 a.m. to 8 p.m.
Mailing Address:	P.O. Box 8738 Dayton, OH 45401-8738
Online:	**CareSource.com**

Member Services can help you:

- Learn about your benefits and what your plan covers.
- Find out if a service needs prior authorization.
- Get a new member ID card.
- Change your primary care provider (PCP).
- Find a provider in the CareSource network.
- File a complaint about CareSource or a provider.
- File a complaint if you think you have been discriminated against.
- Schedule transportation.

Call Member Services to:

- ✓ Let us know if you are pregnant.
- ✓ Change how you want to hear from us. You can get some of your communication from us by email or text if you let us know. You should change your address, phone number or email through your County Department of Job and Family Services.

Have your member ID number handy when you call. This will help us serve you faster.

Accommodations

Are you or someone you care for a CareSource member who:

- Does not speak English?
- Has hearing or vision problems?
- Has trouble reading or speaking English?

We can help. We can get you interpreters for sign language or in the language you speak. Interpreters can help you talk with us or your providers. You can also get materials in other formats like large print, braille, or audio.

We are closed* in 2025 on these days:

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

*Our CareSource24® Nurse Advice Line is open 24/7, 365 days a year.

CareSource24 Nurse Advice Line

Phone: **1-866-206-0554** (TTY: 711)
Open 24 hours a day, 7 days a week, 365 days a year

CareSource24 can help you:

- Learn about a health problem.
- Decide when to go to your doctor, urgent care, or ER.
- Find out more about your medications.
- Find out about health tests or surgery.
- Learn about healthy eating.
- If you have a mental health crisis or concerns and need help.

My CareSource

My CareSource® is a secure account. It uses multi-factor authentication to keep your data safe. Here are a few things you can do in this account:

- Choose or change your primary care provider (PCP).
- View your digital ID card.
- Order a new ID card if you lost it. We will send you a new one in the mail.
- View your claims and plan records.
- View health alerts and more!

Signing up is easy:

1. Go to **MyCareSource.com**.
2. Click *Sign Up* at the bottom of the page.
3. Answer the questions.
4. Click *Register*. You are all set!

Words to Know

Multi-Factor Authentication – Using more than just a password to log in to an account. There are three main methods used:

1. What you know: a password or PIN.
2. What you have: a badge or entering a code from your phone.
3. What you are: a fingerprint or using your voice.

Identification (ID) Cards

You should have received a CareSource member ID card. Each member of your family who has joined CareSource will receive their own card. Each card is good for as long as the person is a member of CareSource. If you had a monthly Medicaid card before, this card will replace it.

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

Call CareSource Member Services as soon as possible at **1-800-488-0134** (TTY: 711) if:

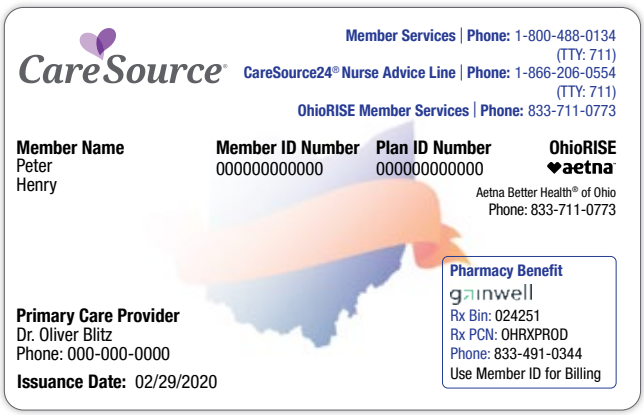
- you have not received your card(s) yet
- any of the information on the card(s) changes or is wrong
- you lose your card(s)
- you have a baby

Always Keep Your ID Card(s) With You

You will need your 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
- schedule transportation

Your CareSource member ID card(s) will look like the ones below.



New Member Information

If you have health care services already approved and/or scheduled, it is important that you call Member Services immediately. In certain situations, and for a specified time period after you enroll, you may be allowed to receive care from a provider that is not a CareSource network provider. 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 Member Services if you have the following services already approved 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 (like wheelchairs, oxygen or a CPAP machine)
- Services you receive at home, including home health, therapies, and nursing

SERVICES COVERED BY CARESOURCE

As a CareSource member, you will receive all medically necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. You should not be billed for these services. If you receive a bill, please call Member Services. Services covered by CareSource are listed in the covered services chart on page 8.

Prior Authorization and Referrals

Some services need to be approved by us before you can get them. **Prior authorization** is the approval that may be needed before you get a service. It must be medically necessary for your care. Your network provider will get prior authorization for the care you need. Network or in-network means that these providers see CareSource members.

Services that need prior authorization are noted in the covered services chart on page 8. You can also call Member Services to learn more.

Referral means that your provider will request these services for you before you can get them. Your provider will either call and arrange these services for you, give you a written note to take with you, or tell you what to do.

Words to Know

Covered Service – medically necessary care that we pay for.

Medically Necessary – care that is needed to diagnose or treat an illness, injury, condition, disease or its symptoms.

Prior Authorization – approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you.

Referral – an order from your provider for you to see a specialist or get certain health care.

Covered Services Chart

Service	More Information	Requirements
Acupuncture	Acupuncture to treat certain conditions like pain management of headaches and lower back pain is covered.	Prior authorization is needed after 30 visits in a year.
Allergy services	Allergy testing and treatment is covered.	
Ambulance and wheelchair van transportation	Taking an ambulance or a wheelchair van is covered for emergencies.	Non-emergency ambulance services need prior authorization.
Behavioral health services (including mental health and substance use disorder treatment)	Mental health and substance use disorder treatment services are available. These services include: • Diagnostic Evaluation and Assessment • Psychological Testing • Psychotherapy and Counseling • Crisis Intervention • Mental Health Services including Therapeutic Behavioral Service, Psychosocial Rehabilitation, Community Psychiatric Supportive Treatment, Assertive Community Treatment for Adults, and Intensive Home-Based Treatment for Children/Adolescents • Substance Use Disorder Treatment Services including Case Management, Peer Recovery Support, Intensive Outpatient, Partial Hospitalization, Residential Treatment, and Withdrawal Management • Medication-Assisted Treatment for Addiction • Opioid Treatment Program Services • Medical Services • Behavioral Health Nursing Services If you need help right away, call 911 or 988. If you need mental health and/or substance use disorder treatment services, you can self-refer and find network providers at **findadoctor.CareSource.com**. You can also call Member Services at **1-800-488-0134** (TTY: 711) to learn more. For answers to health questions 24/7, call the CareSource24 Nurse Advice Line at **1-866-206-0554** (TTY: 711). If you would like to make changes in your life like limiting alcohol use or stopping drug use, we can help. Call the CareSource Addiction Support Line at **1-833-674-6437** (TTY: 711).	These services need prior authorization: • All inpatient services • Children's respite • Assertive Community Treatment (ACT) for adults • Intensive Home-Based Treatment (IHBT) for children/adolescents • Partial Hospitalization Program (PHP) services • Substance Use Disorder (SUD) (Residential: prior authorization is needed after 30 days for the first two admissions and initially for a third admission in a calendar year) • Transcranial Magnetic Stimulation (TMS)

Service	More Information	Requirements
Certified Nurse Midwife services (CNM)	Nurses who help you with pregnancy, labor and giving birth.	No prior authorization is needed to see a CNM. You may self-refer for these services.
Certified Nurse Practitioner services (CNP)	Nurses who are trained in some of the medical care that doctors provide.	No prior authorization is needed to see a CNP. You may self-refer for these services.
Chemotherapy services	Chemotherapy is treatment used to kill cancer cells. These services are covered.	Prior authorization depends on your situation. Work with your provider.
Chiropractic (back) services	Involves adjustments to the spine or other parts of the body.	Chiropractic services need prior authorization after 30 visits in a year if you are younger than 21. Prior authorization is needed after 15 visits in a year if you are 21 or older.
Dental services	Two dental exams and cleanings are covered each year. Dental x-rays are also covered. Your dental benefits are provided by DentaQuest®. Find dentists at www.dentaquest.com. Make sure the dentist knows you are covered by DentaQuest before you visit.	Prior authorization is needed for: • Dental labs and tests • Dentures/Implants • Orthodontics (must be under 21 years old and medically necessary) • Surgeries and procedures
Developmental therapy services	Developmental therapy services for children aged birth to six years old is covered. Call Member Services to learn more.	
Diagnostic services (x-ray, lab)	Lab work, x-rays or tests done to learn more about a specific condition or disease.	Prior authorization is needed for: • Some bloodwork/lab testing • Scans (CT, MRI, PET)
Doula services	A doula advocates and provides support to a mother through pregnancy, labor and childbirth. Many provide services to women postpartum and to those who experience loss of a pregnancy. Doula services are covered. You can get up to six prenatal visits, birth and care after birth, and up to two visits postpartum.	Prior authorization is not needed for doula services. You may self-refer for these services.

Service	More Information	Requirements
Durable Medical Equipment (DME) (breast pumps, breast milk storage bags, walking aid, blood pressure)	Medical equipment and supplies that can be used more than once for health services. Examples of DME are breast pumps, breast milk storage bags, walking aids, blood pressure machines and more. Please call Member Services to learn more. Orthotics can be replaced once each year when medically necessary. More replacements may be allowed if there is damage that cannot be repaired or if you are under the age of 18 and have outgrown your equipment. This excludes repair/replacement if it was lost or stolen, misused, was broken maliciously or from gross neglect.	Prior authorization is needed for: • Wheelchairs and some accessories • All rental/lease items like: CPAP/BiPAP, NPPV machines, apnea monitors, ventilators, hospital beds, specialty mattresses, high frequency chest wall oscillators, cough assist/stimulating device, pneumatic compression devices, speech generating devices and accessories, and infusion pumps • Cochlear implants including most replacements • Left Ventricular Assist Device (LVAD) • Wound vacs • Prosthetic/orthotic devices • Oral appliances for obstructive sleep apnea • Patient transfer systems/hoyer lifts • Power wheelchair repairs • Spinal cord stimulators
Emergency services	An emergency is a medical problem that must be treated right away. Emergency services are always covered. Learn more on page 31.	Emergency services do not need prior authorization. Call 911 or go to the nearest ER.
Family planning services and supplies	Family planning includes things like birth control, family planning exams, nurse midwife services, and prenatal and postnatal doctor and home visits.	Infertility diagnostic services need prior authorization. You can get services from your PCP or any OB/GYN or Qualified Family Planning Provider (QFPP) like Planned Parenthood. You may self-refer for these services.

Service	More Information	Requirements
Federally Qualified Health Center (FQHC) or Rural Health Clinic services (RHC)	FQHCs and RHCs help people who live in rural or urban areas get care. Covered care includes office visits for primary care and specialist services, physical therapy services, speech pathology and audiology services, dental services, podiatry services, vision services, chiropractic services, transportation and mental health services.	No prior authorization is needed to get this covered care.
Free-standing birth center services	Services at a free-standing birth center are covered. Call Member Services for help finding a center or go to **findadoctor.CareSource.com**.	
Gynecological services (OB/GYN)	OB/GYNs care for the female reproductive organs.	No prior authorization is needed for routine OB/GYN services. You can get services from your PCP or any OB/GYN or family planning provider. You may self-refer for these services.
Home health services	Home health care is a wide range of health care services that can be given in your home for an illness or injury.	Prior authorization is needed for: • Home health aide visits • Private Duty Nursing (PDN) • Skilled nurse visits • Social worker visits • Occupational therapy • Speech therapy • Physical therapy
Hospice care	Hospice care is for terminally ill patients.	Prior authorization is needed for inpatient hospice services.
Inpatient hospital services	Procedures or tests done in a hospital or medical center. They usually need an overnight stay.	All inpatient hospital services need prior authorization.
Maternity care	Maternity care - prenatal and postpartum care, including at-risk pregnancy services and gynecological care. Lamaze, breastfeeding, and parent education classes are covered.	Prior authorization is needed if the delivery and inpatient stay is scheduled at less than 39 weeks. It is also needed if the stay is more than 48 hours for vaginal or 96 hours for cesarean delivery.

Service	More Information	Requirements
Medical Nutrition Therapy (MNT) services	Covered care includes diabetic supplies and nutritional supplies.	Prior authorization is needed for: • Continuous glucose monitors • Donor milk • Insulin infusion device • Oral nutrition (for medical purposes) and enteral nutritional therapy
Nursing facility services	We will cover your stay unless the Ohio Department of Medicaid decides that you will return to fee-for-services Medicaid. If you need nursing services, call Member Services for help finding a provider.	Nursing facility services need prior authorization.
Outpatient hospital services	Procedures or tests that can be done in a medical center without an overnight stay.	Elective surgeries need prior authorization.
Pain management services	These services help improve the quality of life if you live with chronic pain. These services are covered: • Epidural injections • Facet medical nerve block • Peripheral nerve blocks • Transcutaneous Electrical Nerve Stimulation (TENS) • Trigger point injections	Prior authorization is needed for: • Epidural injections • Facet medical nerve block • Trigger point injections Epidural injections, facet medical nerve blocks, and peripheral nerve blocks are limited to six each year. Trigger point injections are limited to eight days each year. 2-Lead TENS units are limited to one each month. 4-Lead TENS units are limited to two each month.

Service	More Information	Requirements
Pharmacist services/ provider-administered drugs (all other pharmacy services are covered by ODM's contracted Single Pharmacy Benefit Manager (SPBM))	Pharmacist services - We cover medically necessary visits with a pharmacist to manage your mediations, give you immunizations, or other medications. Provider Administered Drugs - We cover medically necessary drugs that are typically infused or injected and given to you by a provider in an office or other outpatient clinical setting. These drugs may need prior authorization before your provider can give you the drug. All other pharmacy benefits are provided by Gainwell, the single pharmacy benefit manager for all Ohio Medicaid members. Please call Gainwell Member Services at **1-833-491-0344** (TTY: 1-833-655-2437) if you have any questions.	
Physician services	Services given by a provider. Your PCP will do your checkups, shots, and treat you for most of your routine health care needs. If needed, your PCP will send you to specialists or admit you to the hospital.	
Physical and occupational therapy	Physical therapy treats pain and weakness through exercise and other therapies. Occupational therapy can help improve your cognitive, physical, and motor skills.	Physical and occupational therapy needs prior authorization.
Physical exam	A checkup with a provider to go over your medical history and check your health and fitness. A physical exam required for employment or for participation in job training programs if the exam is not provided free of charge by another source is covered.	
Podiatry (foot) services	Services for your feet.	
Prescription drugs	Your pharmacy benefits are provided by Gainwell Technologies, the single pharmacy benefit manager for all Ohio Medicaid members. Prescription drugs including certain prescribed over-the-counter drugs are covered. Please call Gainwell Member Services at **1-833-491-0344** (TTY: 1-833-655-2437) if you have any questions.	Prior authorization varies by drug. Please visit **spbm.medicaid.ohio.gov** to view the prior authorization list.

Service	More Information	Requirements
Preventive mammogram breast cancer and cervical cancer screenings	Screenings for breast cancer (mammograms) and cervical cancer (pap tests) are covered.	Mammograms are limited to one when you are between the ages of 35 and 39. After that, they are covered each year. Pap tests are covered every three years between the ages of 21-29. If you are 30 or older, they are covered every five years.
Preventative prostate screening	Screenings for prostate cancer are covered at one each year.	
Primary care provider (PCP) services	You will get most of your preventive care from your PCP. They will do your checkups, shots and treat you for most of your routine health care needs. Your PCP will refer you to specialists or admit you to the hospital, if needed.	
Private duty nursing services	In home skilled nursing care for members who need continuous nursing services beyond the plan benefit. It must be provided by registered nurse (RN) or a licensed practical nurse (LPN).	Prior authorization is needed for private duty nursing services.
Renal dialysis (kidney disease) services	Dialysis is a procedure where toxins and extra fluids are filtered out of your blood. It is a covered service.	
Residential treatment	Places where you get therapy for substance use disorder, mental illness, or other behavioral problems.	Prior authorization is needed for residential treatment.
Respite services	Care for people who are elderly or who have a disability so that their caregivers can have some time off. Respite is covered for caregivers of those under 21 years old that have long term care or behavioral health needs.	Respite services need prior authorization. It is limited to 100 hours each year.
Screening and counseling for obesity	Tests to find out if you are obese or are at risk for it. It is followed by services to help you lose weight and stay at a healthy weight. Obesity/BMI screening and dietary counseling are covered. Your PCP or other provider can provide this care.	

Service	More Information	Requirements
Services for children with medical handicaps (Title V)	Services for children with medical handicaps are covered.	Your PCP or a specialist with a referral from a PCP can provide this care.
Shots (immunizations)	A shot or immunization helps keep you from getting sick. Some shots protect you for years from diseases. Others are needed every year, like the flu shot. Work with your provider or pharmacist to get your shots at the right time.	
Specialist services	Doctors who focus on a certain kind of medicine or have special training in a certain type of health care. Examples are dermatologists, cardiologists and oncologists. Find specialists at **findadoctor.CareSource.com** or by calling Member Services.	Your PCP will give you a referral to see most specialists. Specialists outside of our network need prior authorization.
Speech and hearing services, including hearing aids	Hearing exams are covered at no cost to you. Hearing aids and related items are covered for those under the age of 21.	Prior authorization is needed for: • Speech therapy • Hearing aids Speech therapy is limited to 30 visits each year.
Telehealth services	Visit with a provider by phone or computer from wherever you are. You can use telehealth for many illnesses and injuries, common health issues, follow-up visits, screenings, and for prescribing medicine. Your PCP may offer telehealth. Contact their office to find out. You can also visit with a medical or behavioral health provider through Teladoc® at no cost to you. Call 1-800-835-2362 or visit Teladoc.com/CareSource to get started.	
Tobacco cessation services	Tobacco cessation services, including tobacco cessation counseling and FDA approved medications for tobacco cessation are covered. Call the Ohio Tobacco Quit Line at 1-800-QUIT-NOW (1-800-784-8669). They are open 24 hours a day, 7 days a week including holidays. Interpreters are available if you do not speak English.	

Service	More Information	Requirements
Vision (optical) services, including eyeglasses	Includes eye exams, routine checkups, and services from an eye doctor. • One comprehensive exam each year for those under 21 years old. • One comprehensive exam every two years for those 21 years and older. Eyeglasses are covered: • Everyone through 59 years old: one pair every two years, one replacement pair if needed. • 60 years and older: one pair per year. • Deluxe frames, transitions, and progressive lenses are not covered. • Up to $100 towards the fitting fee and new contacts is covered. Your vision benefits are provided through Superior Vision®. Find eye care providers at **findadoctor.CareSource.com** or by calling Member Services. Make sure the provider knows you are covered by Superior Vision before you visit.	Vision surgery needs prior authorization.
Well-child (Healthchek) exams for children under the age of 21	Healthchek covers medical exams, immunizations (shots), health education and lab tests for those under the age of 21. Healthchek also covers medical, vision, dental, hearing, nutritional, developmental and behavioral health exams. See page 33 to learn more.	
Yearly well-adult exams	A yearly well-adult exam is a checkup with a provider to go over your medical history and check your health and fitness. This is covered at one visit each year.	

Services Not Covered By CareSource

CareSource will not pay for services or supplies received that are not covered by Medicaid:

- All services or supplies that are not medically necessary
- Paternity testing
- Services to find cause of death (autopsy) or services related to forensic studies
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual

If you have a question about whether a service is covered, call Member Services at **1-800-488-0134** (TTY: 711). We are open Monday through Friday from 7 a.m. to 8 p.m.

Services Not Covered by CareSource Unless Medically Necessary

CareSource reviews applicable State regulations and conducts a medical necessity review, if needed. CareSource will not pay for the following services that are not covered by Medicaid **unless determined medically necessary**:

- Abortions except in the case of a reported rape, incest or save the life of the mother
- Biofeedback services
- 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 (in-patient detoxification services in a general hospital are covered)
- Plastic or cosmetic surgery
- Services for the treatment of obesity
- Services determined by Medicare or another third-party payer
- Sexual or marriage counseling
- Voluntary sterilization if under 21 years of age or cannot legally consent to the procedure

Frequency Limitations

Your managed care organization will review all requests for services from your provider. If you have a question about whether a service is covered, please call Member Services at **1-800-488-0134** (TTY: 711). We are open Monday through Friday from 7 a.m. to 8 p.m.

BENEFITS

Mental Health

Your mental health is a key part of your overall wellness, just like your physical health. That's why we offer mental health and substance use services as a core part of your benefits. Whether it's depression, anxiety, alcohol or drug dependence, we can help. Call Member Services or visit **findadoctor.CareSource.com** to find providers. Please see page 8 to learn more about what mental health and substance use disorder treatment services are covered.

CareSource Crisis Line

Speak to a licensed professional who has behavioral health training. Call **833-687-7302** (TTY: 711). We are here for you 24/7.

CareSource Addiction Support Line

If you would like to make changes in your life like limiting alcohol use or stopping drug use, we can help. Call the CareSource Addiction Support Line at **1-833-674-6437** (TTY: 711).

Dental Care

Good dental care is a key part of your health. You should see a dentist every six months. Routine dental exams can help find and correct any problems before they get worse. Two routine dental exams and cleanings are covered each year. Dental x-rays are also covered.

DentaQuest

Your dental benefits are provided by DentaQuest®. Find dentists at www.dentaquest.com. Make sure the dentist knows you are covered by DentaQuest before you visit.

Vision Care

Caring for your eyes can lead to a better quality of life. Your eyesight impacts your performance at work, school, and home. Routine checkups, services from an eye doctor, and glasses are covered by CareSource.

Superior Vision

Your vision benefits are covered by Superior Vision®. Find eye care at **findadoctor.CareSource.com** or by calling Member Services. Make sure the provider knows you are covered by Superior Vision before you visit.

EXTRA BENEFITS

CareSource also offers the following extra services and/or benefits to their members.

CareSource Life Services

Good health requires more than just quality health care. Having a good job, community support, and access to education or training impacts your overall health and well-being. That's why CareSource Life Services® is here for you. We can help remove barriers that stand in the way of reaching your goals. We can help pave the way from where you are, to where you want to be.

If you are at least 14 years old or parent or guardian of a CareSource member, you can be part of CareSource Life Services. We can link you to services and support for:

- Transportation
- Access to food
- Budgeting and finance help
- Legal assistance
- Housing
- Childcare
- Employment opportunities

CareSource JobConnect

CareSource JobConnect™ helps you develop new skills, links you with local services, and helps you find a job. You'll be paired with a Life Coach who can set you up for success. Life Coaches provide one-on-one coaching for up to 24 months. CareSource JobConnect partners with employers to help you in your job search.

This is all provided at no cost to you. To learn more, please fill out our online form at **secureforms.CareSource.com/en/LSRInfo/**. You can also call us at **1-844-543-7378** or email **LifeServices@CareSource.com**.

myStrength

Take charge of your mental health! myStrength℠ has personalized support to better your mood, mind, body and spirit. Get it through your My CareSource account or visit https://bh.mystrength.com/CareSource to sign up.

MyHealth

Through MyHealth, adults ages 18 and older have access to interactive health assessments, small step guides and videos, and online tools to set and track health and wellness goals. You can even earn rewards for some activities. To get started, simply log in to your My CareSource account, click on the *Health* tab and scroll down to the *MyHealth* link.

MyResources

MyResources helps you find low or no-cost programs in your community for food, shelter, school, work, financial support and more! Go to **CareSource.findhelp.com**. You can also call Member Services to find support near you.

Weight Watchers

If you are ready to take steps toward better health like losing weight, we are here to help. We offer 12 weeks of Weight Watchers to you at no cost. Weight watchers can help you learn how to build healthy habits based on your own needs and lifestyle. Work with your care manager or call Member Services to get started. Exclusions apply.

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. CareSource also covers all necessary transportation by ambulance or wheelchair van, regardless of distance. Please call Member Services at **1-800-488-0134** (TTY: 711) at least two business days in advance for help.

Schedule a ride using your smartphone! Use your phone's camera to scan the QR code to get the app.

If you are pregnant, you can get an unlimited number of rides to the doctor for prenatal care. We want you and your baby to be healthy!

You also get 30 extra round trips per member each year to any healthcare, Women, Infants and Children (WIC), or redetermination appointments. We also cover rides to pick up prescriptions from a pharmacy. If you use your own vehicle to get to your covered medical visits, you may be eligible for mileage reimbursement. Contact Member Services to learn more.

Prefer to use public transportation? We can help! Call Member Services to learn more.

In addition to the transportation assistance that CareSource provides, you can get 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.

Transportation for Food

We offer rides to food pantries, grocery stores for curbside pickup, or other food distribution sites at no cost to you. These rides are in addition to the number you get for covered health services. You can get free rides to and from:

- Food pantries or food banks.
- Churches for food distribution pickups.
- Food distribution pickups through other community organizations.
- Grocery stores to pick up a grocery order (such as curbside pickup).

Call Member Services and tell them you are scheduling a food trip. Make sure that you call to schedule your ride two business days before your planned trip. Rides to grocery stores are for curbside pickup only. If you need a ride to get groceries for curbside pickup, make sure you give your order number, store location, and timeslot for pickup when you call.

Transportation Tips and Rules

These rules make sure that you stay safe and avoid any delays. We want your transportation experience to be positive. Please call Member Services if you have any questions or concerns.

- ✓ When possible, please schedule your transportation 48 hours before you need a ride. You can get a ride in the same day for urgent trips like:
  - when you are discharged from the hospital,
  - need to go to an urgent care, or
  - need to go to your provider for an urgent visit.
- ✓ When you schedule your ride, please let us know if you have any special needs or instructions. Examples are if you use a walker or wheelchair, need to meet at a back entrance, or do not have a phone where the driver can reach you. This will help us better meet your needs.
- ✓ Have the full address of your provider's office, pharmacy or grocery store that you are going to.
- ✓ Be at your pick-up address no later than the time given as your earliest pick-up time. This will give the driver enough travel time so that you will not be late.
- ✓ Be ready when the driver gets there. The driver can wait for only five minutes. After five minutes, they will leave and this will count as one of your 30 trips for the year.
- ✓ If you are not going to go to your appointment, please call to cancel your ride at least two hours before your scheduled pick-up time.
- ✓ It may count as a no-show trip if you are not ready and waiting for pickup. 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 when:
  - You are not at the pick-up address at the time given as your earliest pick-up time.
  - The driver waits five minutes and leaves.
  - You do not call to cancel at least two hours before the scheduled pick-up time.
- ✓ Ask your 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 office before you leave, please do so before requesting your ride home. This ride home may be given by Lyft® or Uber® and they could arrive before you are outside.
- ✓ You must be polite and show respect to the transportation company and CareSource staff. Bad behavior can mean a six-month suspension of transportation for your family. This includes:
  - Swearing, name-calling, or verbal abuse.
  - Threats of physical abuse to the drivers or CareSource staff.

Please call Member Services if you have a concern or question about your transportation services. We are happy to help.

CareSource and the transportation company have the right to immediately stop transportation services if you violate these rules or abuse the transportation benefit.

REWARD PROGRAMS

Make life more rewarding! Earn rewards when you take an active role in bettering your health.

CareSource MyKids

We want all kids to have what they need to live a healthy life. All kids, newborns through age 17, can earn rewards when they complete healthy activities or get preventive care. The rewards are added to a rewards card to use at local stores. Use this card to buy **groceries, school supplies, diapers, personal care items and more*!**

How Does it Work?

1. Sign up for CareSource MyKids first. Fill out the form at **CareSource.com/MyKids** or call Member Services to sign up. Make sure you enroll each child. If you are 17 years old or younger and pregnant, both you and your baby should sign up.
2. After you sign up and complete your first action on the chart, we will send you a rewards card in the mail. Please keep this card in a safe place.
3. Activate your rewards card once you get it in the mail. Call 1-833-832-7306 (TTY: 711) or visit HealthyBenefitsPlus.com/CareSourceMDC to activate it. You can also check your reward balance here.
4. Rewards are added to your card as you complete healthy activities. For rewards where you need to see a provider, they will send a claim to CareSource. We will add the rewards to your card after we process the claim. It can take up to 60 days after we get the claim before a reward is added.
5. Use your rewards card at local stores like you would use a gift card.

Use your rewards card at these stores:

- CVS®
- Dollar General®
- Kroger®
- Walgreens®
- Walmart®
- And many more!

Use your rewards card to buy items like:

- ✓ **Groceries** including fresh and frozen goods and pantry staples
- ✓ **Baby care items** including diapers, wipes and formula
- ✓ **Personal care items** like deodorant, shampoo and toothpaste
- ✓ **Home items** including cleaning products and school supplies

How to Earn Rewards

Action	More Information	Reward Amount	Earn Up To
First prenatal visit	For pregnant women.	$75 per pregnancy.	**$75**
Fifth prenatal visit	For pregnant women. *You must go to visits 1-4 first.*	$50 per pregnancy.	**$50**
12th prenatal visit	For pregnant women. *You must go to visits 1-11 first.*	$50 per pregnancy.	**$50**
Postpartum visit	Complete within 21-56 days after delivery.	$60 per pregnancy.	**$60**
Well-baby visits 1-3	For newborns - 17 months.	$10 each visit.	**$30**
Well-baby visits 4 and 5	For newborns - 17 months. *You must go to visits 1-3 first.*	$20 each visit.	**$40**
Well-baby visits 6 and 7	For newborns - 17 months. *You must go to visits 1-5 first.*	$30 each visit.	**$60**
Lead screening	For ages 12-24 months.	$50 one time.	**$50**
	For ages 25 months - 6 years.	$10 one time.	**$10**
Dental Exam	For ages 3 - 17 years.	$10 twice each year.	**$20**
Well-child visits (18 months – 30 months)	For ages 18 months - 30 months.	$10 up to three times each year.	**$30**
Well-child visit (3 years – 17 years)	For ages 3 - 17 years.	$50 once each year.	**$50**
Vaccination – Dtap, IPV, MMR, and Varicella (given as a series)	For ages 4-6 years.	$20 one time.	**$20**
Vaccination – Tetanus-Diphtheria-Pertussis (Tdap)	For ages 11-17 years.	$15 once each year.	**$15**
Vaccination – HPV	For ages 9-17 years.	$30 one time. *You must complete the series of two shots to earn the reward.*	**$30**
Vaccination – Meningococcal	Recommended ages 11-17 years.	$10 one time.	**$10**

Action	More Information	Reward Amount	Earn Up To
Annual flu shot	For ages 18 months - 17 years.	$25 once each year.	**$25**
ADHD – Follow up visit within 30 days of initial prescription	For ages 18 months - 17 years. *Must have an ADHD diagnosis.*	$10 once each year. *Only rewarded if diagnosis applicable.*	**$10**
ADHD – Follow up visit within 10 months of initial prescription	For ages 18 months - 17 years. *Must have an ADHD diagnosis.*	$10 twice each year. *Only rewarded if diagnosis applicable.*	**$20**

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

Rewards are subject to change. If you are no longer a CareSource member, your account will be deactivated. Any unused rewards may no longer be available. Rewards expire one year after they are issued.

MyHealth Rewards

Adults ages 18 and older can earn rewards through the MyHealth Rewards program. Redeem your rewards for gift cards or to shop on the CareSource online store.

How Does it Work?

1. Adults ages 18 and older are automatically enrolled in MyHealth. Log in to **MyCareSource.com** and click on the *MyHealth* link under the *Health* tab to get started. You can also track your progress and view your balance here.
2. Rewards are added to account as you complete healthy activities. For rewards where you need to see a provider, they will send a claim to CareSource. We will add the rewards to your card after we process the claim. It can take up to 60 days after we get the claim before a reward is added.
3. You can use your rewards to shop on the CareSource Online Store or redeem them for gift cards to your favorite stores to shop for anything from **groceries and clothing to cleaning products and personal care products**. Shop at stores like Walmart®, Old Navy®, Apple®, Domino's® Pizza, Google Play®, Panera Bread® and TJ Maxx®.

How to Earn Rewards

Action	More Information	Reward Amount	Earn Up To
First prenatal visit	For pregnant women.	$75 per pregnancy.	**$75**
Fifth prenatal visit	For pregnant women. *You must go to visits 1-4 first.*	$50 per pregnancy.	**$50**
12th prenatal visit	For pregnant women. *You must go to visits 1-11 first.*	$50 per pregnancy.	**$50**
Postpartum visit	Complete within 21-56 days after delivery.	$60 per pregnancy.	**$60**
Well-baby visits 1-3	For newborns - 17 months.	$10 each visit.	**$30**
Well-baby visits 4 and 5	For newborns - 17 months. *You must go to visits 1-3 first.*	$20 each visit.	**$40**
Well-baby visits 6 and 7	For newborns - 17 months. *You must go to visits 1-5 first.*	$30 each visit.	**$60**
Annual Flu Shot	For adults ages 18 and older.	$25 once each year.	**$25**
Annual physical exam	For adults ages 18 and older.	$50 once each year.	**$50**
Breast Cancer Screening (Mammogram)	For women ages 40-74.	$25 once each year.	**$25**
Cervical Cancer Screening (Pap Test)	For women ages 21 and older.	$40 once every three years	**$40**
Chlamydia Screening	For women ages 18-24.	$25 once each year.	**$25**
Colorectal Screening	For adults ages 45-64. *Reward frequency and amount depends on the screening type.*		
	Colonoscopy	$100 once every 10 years.	**$100**
	Flexible sigmoidoscopy or computed tomography (CT) colonography	$75 once every five years.	**$75**
	Fecal Immunochemical Test (FIT) DNA test	$50 once every three years.	**$50**
	Fecal occult blood test	$25 once each year.	**$25**
Dental exam	For adults ages 18 and older.	$20 twice each year.	**$40**
Diabetes screening – Retinal eye exam, micro albumin, HbA1c	For adults ages 18 and older. *Must have a diabetes diagnosis.*	$75 once each year. You must complete all three screenings to earn the reward. *Only rewarded if diagnosis applicable.*	**$75**

Action	More Information	Reward Amount	Earn Up To
Cholesterol exam	For adults ages 20 and older.	$10 once every five years.	**$10**
Bone density screening	For women ages 65 and older.	$20 each year.	**$20**
Vaccination – HPV	For adults ages 18-26.	$30 one time. *You must complete the series of three shots to earn rewards.*	**$30**
Vaccination – Tetanus-Diphtheria-Pertussis (Tdap)	For adults ages 18 and older.	$10 once every 10 years.	**$10**

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

Rewards are subject to change. If you are no longer a CareSource member, your account will be deactivated. Any unused rewards may no longer be available. Rewards expire one year after they are issued.

WHERE TO GET CARE

Access care from the right provider when you need it.

Primary Care Provider (PCP)

Used for common illnesses and advice. You will get most of your preventive care from your PCP. You should see your PCP the most often.

Telehealth

Visit with a provider by phone or computer from wherever you are. Ask your PCP if they offer telehealth. You can also talk to a doctor 24/7 through Teladoc®. Call 1-800-835-2362 or visit Teladoc.com/CareSource to get started.

Convenience Care Clinics

Used for common illnesses like coughs, colds, sore throats and to get shots. They are found in many local drug and grocery stores.

Community Behavioral Health Center (CBHCs)

Give health and social services to people living with mental health or substance use problems. CBHCs are often the first place people go to get help for behavioral health issues.

Urgent Care

Used to treat non-life threatening issues like illnesses or a deep cut. Visit them when your PCP is not available and your health issue cannot wait.

Hospital Emergency Room

Used for life-threatening issues or emergencies like chest pain or a head injury. Call 911 or go to the nearest ER.

Not sure where to go for care? Call our CareSource24® Nurse Advice Line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). We are here for you 24 hours a day, 7 days a week, 365 days a year.

Primary Care Provider

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

- Dizziness
- High or low blood pressure
- Swelling of the legs and feet
- High or 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

Choosing a Primary Care Provider (PCP)

You must choose a primary care provider (PCP) from CareSource's provider directory. Your PCP is an individual provider or provider 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 check-ups, shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other providers, specialists or admit you to the hospital. You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource member ID card.

Changing Your PCP

If you want to change your PCP, you must first call Member Services to ask for the change. You can change your PCP as often as once a month. We will process your change on the day you 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. Member Services can also help you schedule your first appointment, if needed.

For the names of the PCPs in the CareSource network, you may look in your Provider Directory if you requested a printed copy, on our website at **findadoctor.CareSource.com**, or you can call CareSource Member Services at **1-800-488-0134** (TTY: 711) for help.

If your PCP tells us that they are moving, retiring or leaving CareSource for any reason, we will let you know by mail within 45 days. We will assign you a new PCP or help you choose a new PCP from the CareSource network. We will also let you know if any of our network hospitals within your region are no longer in network and give you the nearest hospitals that are in the CareSource network.

Appointments

Please schedule appointments with your provider as far in advance as you can. It is important to keep your appointments. Call the provider's office at least 24 hours before you need to change or cancel a visit. If you miss too many appointments, they may ask that you choose another provider.

CareSource can provide transportation to and from the provider's office. See page 21 to learn more.

When You Can See a Non-Network Provider

It is important to remember that you must receive services covered by CareSource from facilities and providers in CareSource's network. Providers in the CareSource network agree to work with your health plan to give you needed care.

The only time you can use providers that are not in CareSource's network is for:

- emergency services,
- federally qualified health centers (FQHC)/rural health clinics (RHC),
- certified nurse midwives or certified nurse practitioners,
- qualified family planning providers,
- an out of network provider that CareSource has approved you to see.

The Provider Directory lists all our network providers you can use to receive services. You can ask for a printed Provider Directory by calling Member Services or by returning the postcard you received with your new member materials which includes your CareSource member ID card. You can also visit **findadoctor.CareSource.com** to view up to date provider network information or call Member Services at **1-800-488-0134** (TTY: 711) for help. We are open Monday through Friday from 7 a.m. to 8 p.m.

Telehealth

Telehealth is the direct delivery of health care using audio and/or video. Instead of coming into the office for your appointment, you stay at your home or office and use your smartphone, tablet or computer to see and talk to your medical and behavioral health professionals. There is no cost to use telehealth and telehealth removes the stress of needing transportation services. You can see medical and behavioral health professionals via telehealth for many illnesses and injuries, common health conditions, follow-up appointments and screenings as well as for prescribing medication(s). Check with your providers to see if they offer telehealth.

Teladoc

If your provider does not offer telehealth or has limited hours, you can speak to a medical provider 24/7 through Teladoc® from wherever you are. Use Teladoc for common health issues like a cold or flu, allergies and sinuses, pink eye, rashes, infections, and more! The provider can diagnose symptoms and send a prescription as needed.

Teladoc also has mental health providers available seven days a week from 7 a.m. to 9 p.m. They can help with anxiety, depression, stress, substance use, trauma, and more. Visits for mental health must be scheduled ahead of time.

Call 1-800-TELADOC (835-2362) or visit Teladoc.com/CareSource to get started.

Convenience Care Clinics

If you can't see your PCP, we want to make it easy for you and your family to get care when you need it most. A retail visit is quicker and cheaper than a visit to urgent care or an ER. You can go to clinics inside of stores like CVS®, Kroger® and Walgreens® for basic care. At the clinic, you can:

- Get a flu shot.
- Get health screenings and physicals.
- Get care for aches and pains, sicknesses and minor injuries.

Most clinics are open in the evening, 7 days a week. Visits can be scheduled for the same day. Often walk-ins are welcome.

Urgent Care

Go to urgent care if you cannot visit your provider quickly enough. They help keep an injury, sickness, or mental health issue from getting worse. You can find them at **findadoctor.CareSource.com**. Always follow up with your PCP after your visit. If you need transportation to get to urgent care, call Member Services and say you need a same-day trip.

Emergency Services

Emergency services are for a medical problem that must be treated right away by a provider. 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
- Behavioral health emergency

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 care setting.

If you are not sure if you need to go to the ER, call your primary care provider (PCP) or the CareSource24 Nurse Advice Line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). Your PCP or the CareSource24 Nurse 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. Tell them that you are a member of CareSource and show them your CareSource member ID card.
- If the provider treats your emergency, thinks 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 them know that you have a medical emergency, or have someone call for you. Then call your PCP or Member Services as soon as you can after the visit to schedule any necessary follow-up services.
- If the hospital has you stay, please make sure that CareSource is called within 24 hours.

Emergency services do not need prior authorization. You can go to any hospital or other appropriate setting for emergency services. If you are admitted and the facility is not in the CareSource network, you may be transferred to a hospital in the CareSource network once you are stable.

Follow Up Care

You may need more care after your emergency. This is called follow up care (also called post-stabilization care). Let us know that you have had an emergency. If you have a care manager, let them know. They will help you with any follow-up care you need.

We will talk to the providers that give you care during your emergency. They need to tell us if you need more care for issues that may have caused the emergency. They will ask us for approval for this care. We want you to improve.

If your emergency care came from out-of-network providers, we will work to get network providers to take over your care.

When You Travel

Sometimes you get sick or injured while you are away from home. Here are suggestions for what to do if this happens:

- **It's an emergency:** Call 911 or go to the nearest ER.
- **If it's not an emergency:** Call your PCP for help for what to do.
- **If you're not sure it's an emergency:** Call your PCP or CareSource24 at **1-866-206-0554** (TTY: 1-800-750-0750 or 711). We can help you decide what to do.

Emergency or Urgent Care Outside of Our Service Area

If you get emergency care from a provider who is not a network provider, or urgent care services outside the service area for your plan, you may need to submit the bill you get to CareSource with a claim form. You can visit **CareSource.com** and find the Member Claim Form under *Forms* or call Member Services and ask for the form to be mailed to you.

PREVENTIVE CARE

Preventive care is key for the whole family. Seeing your PCP on a routine basis even if you are healthy helps your PCP find and treat problems early before they get worse. Check out the chart of recommended preventive care to get based on your age. The chart is only a guide. Work with your provider to get your preventive care. They will know which recommendations may be right for you based on your health history.

Preventive Care	20's	30's	40's	50's	60 and older
Yearly well-adult exam*	✓	✓	✓	✓	✓
Breast cancer screening (Mammogram) – for women			✓	✓	✓
Cervical cancer screening (Pap test) – for women	✓	✓	✓	✓	✓
Chlamydia screening	✓				
Cholesterol screening	✓	✓	✓	✓	✓
Colon cancer screening			✓	✓	✓
Dental exam*	✓	✓	✓	✓	✓
Diabetes screening	✓	✓	✓	✓	✓
Flu vaccine*	✓	✓	✓	✓	✓
Pneumococcal vaccine					✓
Prostate cancer screening – for men				✓	✓
Shingles vaccine				✓	✓
Tetanus and diphtheria (Td) vaccine	✓	✓	✓	✓	✓
Vision exam	✓	✓	✓	✓	✓

*You can earn rewards by getting this preventive care! Learn more about these rewards on page 23.

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 members under the age of 21. These exams make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at birth, 3-5 days of age and at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months of age. After that, children should have at least one exam per year.

Healthchek covers medical, vision, dental, hearing, nutritional, developmental, behavioral health exams, and other care to treat physical, behavioral, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek is 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:
    - Medical exams (physical and development screenings)
    - Vision exams
    - Dental exams
    - Hearing exams
    - Nutrition checks
    - Developmental exams
    - Lead testing
- Laboratory tests (age and gender appropriate exams)
- Immunizations
- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to:
    - 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
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early. That way your provider can treat them, or make a referral to a specialist for treatment, before the problem gets more serious. *Remember: Some services may require a referral from your PCP or prior authorization by CareSource.* For some EPSDT items or services, your provider may ask for prior authorization for CareSource to cover things that have limits or are not covered for members over the age of 20. Please see pages 8-16 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 who have special health care needs. Please see pages 37-38 to learn more about the care management services offered by CareSource.

How to Get Healthchek Services

Call your PCP or dentist to schedule an appointment for a Healthchek exam. Make sure to ask for a Healthchek exam when you call. If you have questions or would like to learn more about the Healthchek program, please call Member Services. 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 a ride if you need one
- Get referrals for Women, Infant and Children (WIC), Help Me Grow, Bureau for Children with Medical Handicaps (BCMH), Headstart and community services such as food, heating assistance, and more.

PREGNANCY AND FAMILY PLANNING

Mom & Baby Beginnings™

Our team is here for you during and after your pregnancy. We connect you to resources and work with your providers to make sure you are healthy and safe. Our team helps you understand your pregnancy and how to take care of your newborn. We can also help coordinate care if you have a baby in the NICU.
Call **833-230-2034** (TTY: 711) to get started.

Before You Are Pregnant

You can take steps to be healthy now if you are thinking about having a baby. This can limit problems during pregnancy:

- Visit your provider.
- Eat healthy.
- Stop smoking now.
- Take folic acid each day.
- Do not drink alcohol or use illegal drugs.

While You Are Pregnant

See a provider as soon as you know you are pregnant. Seeing your provider on a routine basis while you are pregnant can help find and treat issues early.

After You Have Your Baby

Call CareSource to tell us that you had your baby. Schedule a visit with your provider 3-6 weeks after you have your baby. They can make sure your body is recovering, check on your mental health, and answer any questions you might have. If you had a C-section or had any problems during delivery, make your appointment within the first or second week after your baby is born.

Your body and mind go through lots of changes after you give birth. Nearly one in eight people suffer from postpartum depression (PPD) after they give birth. About one in 10 develop postpartum anxiety (PPA). Your mental health matters. Call your provider right away if you notice any signs or symptoms of PPD. Call 988 to speak to a trained crisis counselor 24/7. You need to take care of yourself just like you take care of your baby.

Feeding Baby

Choosing to breastfeed, formula feed, or a combination of both is a hard decision for many new parents. Breastfeeding is beneficial for moms and babies. For moms, it can reduce the risk for diabetes and some cancers. For babies, it can give them more protection from illnesses and decrease the chance of Sudden Infant Death Syndrome (SIDS). If you have issues getting baby to latch or need to be apart from baby, know that pumping milk to bottle feed later is giving baby the same benefits.

Breastfeeding may not be possible for all, or it may not work in your situation. This is okay! Know that formula is a healthy and safe option for babies.

Plan to Breastfeed?

We want you to have the tools you need if you plan to breastfeed. We cover breast pumps and supplies like 100 milk storage bags each month at no cost to you. You can order your breast pump and other supplies online within 90 days of your due date. Visit insured.amedadirect.com, byramhealthcare.com, aeroflowbreastpumps.com, or pumpsformom.com to choose your breast pump. Each website has lots of brands and models for you to choose from. Fill out the information on the website and they will work with us to get your breast pump and supplies to you. Call Member Services if you have any questions.

Mom's Meals

Eating healthy is important no matter what stage of life you are in. After you give birth, healthy eating is critical for both you and your baby. This is true whether you are nursing or not. We offer free meal delivery through Mom's Meals® after you give birth. Get up to 28 healthy meals delivered to your door after you give birth (for eligible members). Work with your care manager or call Member Services to get your meals set up.

CARE MANAGEMENT SERVICES

CareSource offers care management services. The care management team includes registered nurses, social workers, and community health workers. We work with you, your primary care provider (PCP) and/or other specialists, and any family or caregivers you would like to help coordinate your care. Together, we work with you to meet your health and wellness goals. You also have access to a collaborative meeting with your providers and other caregivers. The care management team can help schedule an Interdisciplinary Care Team meeting (ICT).

Care Guides and Care Managers can help with identified needs. Care Managers are licensed professionals - nurses, social workers or counselors - and are able to provide long-term care coordination. Care Guides have experience in care coordination and help with short-term needs, such as referrals to community resources or helping you learn how to get the most from your benefits and services.

Care management is available for anyone. It is especially helpful if you have any of these conditions:

- Anxiety
- Asthma
- Autism
- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Chronic kidney disease/End Stage Renal Disease (ESRD)
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive heart failure
- Coronary artery disease
- Depression
- Diabetes
- Hepatitis C/ liver disease
- Hypertension
- Pregnancy
- Sickle cell disease
- Substance use disorder

Care management includes different levels of care. The level of care you receive depends on your condition and how much help you need managing your health care needs. One of the easiest ways to get started is by completing your Health Risk Assessment (HRA). Using a few questions about your health and lifestyle, we can determine the level of care management you may need.

You can take the HRA in one of these ways:

1. **Phone:** Call **1-833-230-2011** (TTY: 711) Monday through Friday between 7 a.m. to 6 p.m.
2. **Online:** Just log into your secure **MyCareSource.com** account and click on the *Health* tab.

The care management team may ask you questions to learn more about your specific health conditions. This way, we can help you understand your condition and how to better manage your health. We will also help you access services and local resources. We can connect you with resources you need like food, clothing, and housing. We can even help you coordinate transportation to get medical care.

CareSource also has a team of specially trained nurses and social workers for babies admitted to the Neonatal Intensive Care Unit (NICU). Our team works with hospitals to help you get ready to bring your baby home.

You may hear from the care management team if:

- Your PCP or other provider asks us;
- You or your caregiver asks us to contact you;
- We think we can help you based on your medical history.

Please call us if you have any questions or feel that you would benefit from care management services. We are happy to help. You can reach us by calling Member Services and asking for care management.

Care Transitions

We help you or your family after you leave the hospital by:

- Answering questions about discharge.
- Making sure that you or your family have your medications and understand what they are for.
- Coordinating care with your PCP and/or specialists, including getting any needed follow up care.
- Getting any needed equipment or supplies for you or your family's care at home.

If you or your family need help after leaving the hospital you can reach the Care Transition team at **1-866-867-0421** (TTY: 711).

Disease Management

We know that living with a chronic health condition can be hard. We want you to have the right tools to stay healthy. If you are living with chronic health condition like diabetes or high blood pressure, our disease management programs are for you.

Our free disease management programs can help you learn more about your health. They can also help you manage your health condition. You can choose to be part of a program or we may hear from your doctor, pharmacy, or other provider that you would benefit from one of our programs. Please call us at **1-844-438-9498** (TTY: 711) if you would like to be part of a program. You can also opt-out by calling this number. We want to help you be healthy and well.

OHIORISE

OhioRISE (Ohio Resilience Through Integrated Systems and Excellence) is a Medicaid managed care program for children and youth with complex behavioral health and multisystem needs. Children and youth with multisystem needs are often involved in multiple community systems such as juvenile justice, child protection, developmental disabilities, education, mental health and addition, and others. OhioRISE aims to support these children and youth succeed in their schools, homes, and communities. This support is provided through care coordination and specialized services that are provided in-home or in the young person's community.

Children and youth who may benefit from OhioRISE:

- Have multiple needs that result from behavioral health challenges.
- Have multisystem needs or are at risk for deeper system involvement.
- Are at risk of out-of-home placement or are returning to their families from out-of-home placement.

An individual who is enrolled in the OhioRISE program has their physical health services covered by managed care organizations (MCO) or fee-for-service (FFS) Medicaid.

OhioRISE Eligibility

A child and youth may be eligible for OhioRISE if they:

- Are eligible for Ohio Medicaid.
- Are under the age of 21, and
- Need significant behavioral health treatment, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment, or
- Are in a hospital for mental health or substance use needs.

OhioRISE Services:

In addition to the behavioral health services already available through Medicaid, OhioRISE offers the following services:

- Care Coordination – Assistance with planning support and care for a child or youth's behavioral health needs. Their care coordinator through their managed care organization (MCO) can also be part of this process. Intensive Home-Based Treatment (IHBT) – Intensive, short-term services within a child or youth's home to help stabilize and improve their behavioral health.
- Behavioral Health Respite – Short-term relief to the primary caregivers of a child or youth who is in a home or community-based environment. Primary Flex Funds - $1,500 in a 365-day period to purchase certain resources that address a specific need for a child or youth.
- Psychiatric Residential Treatment Facility (PRTF) – Facilities, other than hospitals, that provide intensive psychiatric residential treatment services to individuals ages 20 or younger.
- Mobile Response and Stabilization Services (MRSS) – Immediate behavioral health services for children/youth in crisis. MRSS helps to ensure children and youth receive urgent, necessary care in their homes and communities. This service is also provided through Medicaid managed care organizations (MCO) and fee-for-service (FFS) Medicaid.

CANS Assessments

To have a child or youth assessed for OhioRISE, contact CareSource Member Services at **1-800-488-0134** (TTY: 711). We will help find a CANS assessor in the child or youth's community to have the CANS assessment completed.

OhioRISE Contact Information

For more information on OhioRISE services, contact CareSource Member Services at **1-800-488-0134** (TTY: 711) or Aetna OhioRISE Member Services at (833) 711-0773 (TTY: 711).

PHARMACY

Prescription Drugs

MCO members will use Gainwell, ODM's contracted SPBM, to fill prescriptions and will need to refer to the Gainwell member handbook for assistance. SPBM stands for Single Pharmacy Benefit Manager. All Ohio Medicaid members use Gainwell, no matter what managed care plan they are part of. Visit **spbm.medicaid.ohio.gov** to find a pharmacy or learn more about prescriptions. Please call Gainwell at **833-491-0344** if you have any questions.

Ask Your CareSource Pharmacist

Do you have questions about your medications? Talk to a CareSource pharmacist. They can look over your medications with you and answer questions. You do not need an appointment! Call **1-833-230-2073** (TTY: 711) to speak with a pharmacist today. We are open Monday through Friday, 8 a.m. to 5 p.m.

Coordinated Services Program (CSP)

Some CareSource members may be enrolled 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 an emergency or for after-hours services, CSP members:

- Must have one pharmacy to fill their controlled substances.
- May be assigned to one PCP who will coordinate care with other providers.

Members can ask to change their pharmacy or PCP under limited circumstances. If you are enrolled in CSP, we will let you know in writing. We will give you more information about CSP and let you know about your state hearing rights.

Medication Therapy Management

Using medications the right way is vital to your health. Our Medication Therapy Management (MTM) program will:

- Help you safely use your medications.
- Help your doctors and other caregivers work better together.
- Help you learn about your drugs and the right way to use them.
- Help your overall health.

You can work one-on-one with a pharmacist through the MTM program. They can go over and help you manage your medications. Ask your pharmacist if they are part of the MTM program. You can also call Member Services to learn more.

Medication Disposal

Do you have expired drugs or medications you no longer use? These drugs can be a health risk for toddlers, teens, or pets if they are within reach. They can also be misused. Most people who misuse prescription drugs get them from friends or family.

Drug take back sites like local pharmacies or police stations can safely get rid of these drugs for you. Visit **deadiversion.usdoj.gov/pubdispsearch** to see a list of sites near you.

CareSource has free packets that help you get rid of expired drugs or medications you no longer use. These packets are safe, easy to use, and will help reduce drug misuse. Visit **secureforms.CareSource.com/DisposeRx/** to get your free packet today.

YOUR MEMBERSHIP RIGHTS

As a member of CareSource, you have the following rights:

- To receive all information and services that CareSource must provide. This includes information about CareSource, our services, our providers, and member rights and responsibilities. It can also be information about any provider incentive plan we may have.
- 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 approved 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 medically necessary treatment options for your condition(s), no matter the cost or benefit coverage.
- To participate with providers in making decisions relating to your health care.
- To be able to take part in decisions about your health care as long as the decisions are 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, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say “yes” or “no” to having any information about you given out unless CareSource must by law.
- To say no to treatment or therapy. If you say no, the provider or CareSource must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See page 47 of this handbook to learn more.
- To get help free of charge from CareSource and its providers if you do not speak English or need help in understanding information.

- To get all written member information from CareSource:
  - at no cost to you.
  - in the prevalent non-English languages of members in the CareSource service area.
  - in other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- 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 their 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 page 58 to learn more about advance directives.
- 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 in the CareSource network at least monthly. CareSource must send you something in writing that says who the new PCP is by the date of the change.
- To be free to carry out your rights and know that CareSource, the CareSource providers or the Ohio Department of Medicaid 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 in the CareSource network for covered woman's health services.
- To get a second opinion from a qualified provider in the CareSource network. If a qualified provider is not able to see you, CareSource must set up a visit with a provider not in our network.
- To get information about CareSource from us.
- To voice a complaint or make an appeal about CareSource or the care it provides.
- To make recommendations about CareSource's member rights and responsibilities policy.
- To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint

of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

The Ohio Department of Medicaid

Address:	The Ohio Department of Medicaid Office of Human Resources, Employee Relations P.O. Box 182709 Columbus, Ohio 43218-2709
Email:	ODM_EmployeeRelations@medicaid.ohio.gov
Fax:	(614) 644-1434

Office for Civil Rights

Address:	Office for Civil Rights United States Department of Health and Human Services 233 N. Michigan Ave. – Suite 240 Chicago, Illinois 60601
Phone:	(312) 886-2359 TTY: (312) 353-5693

YOUR MEMBERSHIP RESPONSIBILITIES

As a member of CareSource you have the responsibility to:

- Use only approved providers in the CareSource network.
- Keep doctor and dentist appointments, be on time, and call 24 hours before the scheduled appointment to cancel.
- Follow the advice and instructions for care you have agreed to with your PCP and other providers.
- Always carry your ID card. Show it when getting care.
- Never let others use your ID card.
- Tell your county caseworker and CareSource of a change in phone number or address.
- Contact your PCP after going to an urgent care or after getting medical or behavioral health care.
- Let CareSource and your county caseworker know if you are covered by other health insurance.
- Provide the information that CareSource and your providers need, to the extent possible, in order to provide care.
- Tell us of suspected fraud as described in the Fraud, Waste and Abuse section of this handbook.
- Understand as much as possible about your health issues and take part in reaching goals agreed to with your health care provider.

APPEALS AND GRIEVANCES

If you are unhappy with CareSource or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to give us your approval in writing. CareSource wants to help.

To contact us, you can:

- Call our Member Services Department at **1-800-488-0134** (TTY: 711),
- Fill out the form in your member handbook (see page 81),
- Call our Member Services Department to ask for a printed copy,
- Visit our website at **CareSource.com**,
- Write a letter telling us what you are unhappy about. Please include 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 and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

CareSource will send you something in writing if we decide 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.
- deny payment for a service you received that is not covered by CareSource.

We will also send you something in writing if we did not:

- decide on whether to cover a service requested for you, or
- give you an answer to something you told us you were unhappy about.

Words to Know

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

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

Appeals

If you do not agree with the decision or action listed in the letter, you can contact us **within 60 calendar days** to ask that we change our decision or action. This is called an **appeal**. The 60 calendar day period begins on the day after the mailing date on the letter. If we have decided 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.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action because of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through CareSource's appeal process.**

You can submit an appeal by filling out the Member Standardized Appeal Form at **CareSource.com**, or writing a letter and including:

- The covered person's name and identification number as shown on the ID card
- The provider's name
- The date of the medical service
- The reason you disagree with the coverage denial
- Any documentation or other written information to support your request.

Mail the form or your letter to:
CareSource
Attn: Grievance and Appeals
P.O. Box 1947
Dayton, OH 45401-1947

Grievances

If you contact us because you are unhappy with CareSource or 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. We will give you an answer within the following time frames:

- two working days for grievances about not being able to get services. This is for covered services under your plan.
- thirty calendar days for all other grievances except grievances about getting a bill for care you received.
- sixty calendar days for grievances about getting a bill for care you received.

If we need more time to make a decision for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter will also explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

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

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-605-3040 or 1-800-324-8680 (TTY: 1-800-292-3572)

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
1-800-686-1526

State Hearings

A state hearing is a meeting with you or someone you want to speak on your behalf, someone from the County Department of Job and Family Services, someone from CareSource, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think CareSource did not make the right decision and CareSource will explain the reasons for making our decision. The hearing officer will listen and then decide who is right, based on the rules and the information given.

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

- we do not change our decision or action because of your appeal.
- a decision is made to propose enrollment or continue enrollment in the Coordinated Services Program.
- a decision is made to deny your request to change your Coordinated Services Program provider.

You may only request a state hearing after you have gone through CareSource's appeal process.

If you want a state hearing, you, or someone you want to speak on your behalf, 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 your appeal was about a decision to reduce, suspend, or stop services before all the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the Coordinated Services 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,
- Submit your request online at https://hearings.jfs.ohio.gov/apps/SHARE#_frmLogin
- submit your request via e-mail at bsh@jfs.ohio.gov.

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.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, CareSource or the Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited 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, your health or your ability to attain, maintain, or regain maximum function.

UTILIZATION MANAGEMENT

Our Utilization Management (UM) team includes non-clinical staff, registered nurses, physicians, mental health specialists, and other health experts. They review the health care you get based on a set of guidelines. They go over this care to make sure it is the best for your needs. You can ask how care is reviewed. You can ask about:

- Preservice review
- Urgent concurrent review
- Post service review
- Filing an appeal

We do not reward providers or our staff for denying services. We want you to get the care you need. We can get you an interpreter if you or your family's primary language is not English. We can also help if you have problems with your eyesight, hearing, or have trouble reading.

Call Member Services and ask for the UM team if you have questions. Please keep in mind:

- We are open for calls Monday through Friday from 8 a.m. to 5 p.m.
- You can leave a message about UM issues after these hours.
- Reach UM using the *Tell Us* form at **CareSource.com**.
- UM staff who call you will say their name and title and that they are from CareSource.

Authorization Time Frames

We will decide standard requests within 10 calendar days after we get your request. We will tell you and your provider if it has been approved. You, your provider, or CareSource can ask for more time to review. The review can last up to an additional two weeks.

Your provider or CareSource can ask for an urgent authorization. This would be for a non-life-threatening issue that a provider who knows your issue thinks needs quick medical care. This helps prevent:

- ✓ A serious threat to life, limb, or eyesight.
- ✓ Worsening function or damage to any part of the body that threatens the body's ability to get better.
- ✓ Severe pain that cannot be managed without quick medical care.

We will decide these requests within 48 hours. We can ask for up to an additional 14 calendar days for review.

New Care Approvals

We may decide to cover a new treatment that is not covered by Medicaid. This can be new:

- Health care services
- Medical devices
- Therapies
- Treatments

Review of New Technology

We depend on research and advances in science to provide you with evidence-based, high quality-care. Our New Technology Committee, made up of physicians across CareSource, evaluate medical advances to determine their quality and safety. Network providers may submit requests for evaluation. By regularly reviewing medical technologies and our benefit coverage, we strive to provide up-to-date, effective, and affordable medical care.

We review requests for new technology that are not currently covered. This involves:

- Changes to Medicaid rules
- External technology assessment rules
- Food and Drug Administration (FDA) approvals
- Medical literature recommendations

PRIVACY PRACTICES

Your Rights

When it comes to health information, you have the right to:

Get a copy of your health and claims records. You can ask for a copy of your health and claims records. 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 health and claims records if you think they are wrong or not complete. We may say “no” to requests. If we do, we will tell you why in writing within 60 days.

Ask for private communications. You can ask us to reach you in a specific way, such as home or office phone. You can ask us to send mail to a different address. We will consider 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 these requests. We may say “no” if it would change your care or for certain other reasons.

Get a list of who we have shared information with. You can ask how many times we’ve shared your health information. This is only up to six years before the date you asked. You can ask who we shared it with and why. We will include all the disclosures except for those about:

- Care,
- Amount paid
- Health care operations
- Other disclosures that you asked us to make

We will give you one list each year for free. We will charge a fair, cost-based fee if one is asked for within 12 months.

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 agreed to get the notice electronically. We will give you a paper copy as soon as possible.

Allow CareSource to speak to someone on your behalf. You can allow us to talk about your health information with someone else on your behalf. Legal guardians can make choices about your health information. We will give health information to the legal guardian. We will make sure they have this right and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

- You can send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201
- Call 1-877-696-6775, or
- Visit **www.hhs.gov/ocr/complaints/index.html**.

We will not take action against you for filing a complaint. We cannot ask you to give up your right to file a complaint as a condition of:

- Care
- Payment
- Enrolling in a health plan
- Eligibility for benefits

Your Choices

For certain health information, you can choose what we share. You should tell CareSource how you want this information shared. We will follow these orders. In these cases, you have the right and choice to tell us to:

- Share information with your family, close friends, or others who pay for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your choice, such as if you are unconscious, we may go ahead and share your information. We may share it if we believe it is in your best interest. We may also share your information when needed to lessen a serious and close threat to health or safety. We cannot share your information unless you have given us written consent for:

- Marketing purposes
- Sale of your information
- Sharing your therapy notes

Consent to Share Health Information

Our policy is to share your health information. This includes Sensitive Health Information (SHI) such as drug and/or alcohol treatment, genetic testing results, HIV/AIDS, mental health, sexually transmitted diseases (STDs) or other diseases that are a danger to your health. We share this for treatment, care coordination and help with benefits. It is shared with your past, present and future providers. It is also shared with the Health Information Exchange (HIE). HIE lets providers view information that we have about you.

You have the right to tell us if you do not want your health information (including SHI) shared. If you do not agree to share your health information, it will not be shared with providers to handle your care and treatment or to help with benefits. It is still shared with the provider who treats you for the specific SHI. If you do not approve sharing, your providers may not be able to coordinate your care as well as they could if you did approve sharing.

Other Uses and Disclosures

We use or share your health information in these ways:

- **Help you get health care.** We can use your health information and share it with experts who are treating you. *Example: A doctor sends us your diagnosis and care plan so we can arrange more care.*
- **Pay for your health care.** We can use and give out health information when we pay for health care. *Example: We share information about your dental plan to pay for dental work.*
- **Operate the plan.** We may use or share your health information to run our health plan. *Example: We may use your information to make the quality of health care better. We may give your health information to outside groups so they can help us run the health plan. Outside groups are lawyers, accountants, consultants, and others. They keep your health information private, too.*

We may share your information in other ways. This is often for the public good, such as public health and research. We have to meet many rules in the law before we can share your information. To learn more, see www.hhs.gov/hipaa/index.html.

- **To help with public health and safety issues.** This is to:
  - Prevent disease.
  - Help with product recalls.
  - Report harmful reactions to drugs.
  - Report suspected abuse, neglect, or domestic violence.
  - Prevent or reduce 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 if certain privacy rules are met.
- **To obey the law.** We will share information if state or federal laws call for it. This involves the Department of Health and Human Services if it wants to see that we are obeying federal privacy laws.
- **To react to organ and tissue donation requests and work with a medical examiner or funeral director.** We can share health information with organ donation groups. We can also share with a coroner, medical examiner, or funeral director if you die.
- **To address certain orders.** We can use or share health information for:
  - Workers' compensation claims
  - Law enforcement purposes or with a police official
  - Health oversight offices for actions allowed by law
  - Special roles such as military, national safety, and presidential protective services
- **To react to lawsuits and legal actions.** We can share health information due to a court or legal order. We may also make a group of "de-identified" information that cannot be traced back to you.

Our Responsibilities

- We protect your health information in many ways. This includes information that is written, spoken, or found online through a computer.
  - Our staff is trained on how to keep your information safe.
  - Your information is talked about in a way so that it is not overheard.
  - We make sure that our computers are safe by using firewalls and passwords.
  - We limit who can get your health information. We make sure that only staff with a business need can get information.
- By law, we must keep the privacy and security of protected health information and 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 in this notice.
- We will not use or share your information other than as listed here. This is unless you tell us we can in writing. You can change your mind at any time and tell us in writing.

Learn more at www.hhs.gov/hipaa/for-individuals/index.html.

Effective date and changes to the terms of this notice
The original notice was effective April 14, 2003, and this version was effective June 18, 2018. We must follow the terms of this notice as long as it is in effect. If we change the notice, the new one would apply to all health information we keep. If this happens, we will put the new notice on our web site. You can also ask our Privacy Officer for it.

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

Email: HIPAAPrivacyOfficer@CareSource.com

Phone: **1-800-488-0134** (TTY: 711)

FRAUD, WASTE AND ABUSE

Our Program Integrity team handles cases of fraud, waste and abuse. Examples are:

Providers who:

- Order drugs, equipment or services that are not medically necessary.
- Do not give medically necessary services due to lower reimbursement rates.
- Bill for tests or care that they do not give.
- Use wrong medical coding on purpose to get more money.
- Have you come for more visits than are needed.
- Bill for more expensive care than what you get.
- Unbundle services to get a higher repayment.

Pharmacies that:

- Do not fill prescriptions as written by your provider.
- Send claims for a brand-name drug that costs more but give you a generic or a cheaper drug.
- Give less than the prescribed amount and do not let you know to get the rest of your medication.

Members who:

- Sell prescribed drugs or try to get controlled drugs from more than one doctor or pharmacy.
- Change or forge prescriptions.
- Use pain medications you do not need.
- Share your ID card with someone else.
- Do not tell us that you have other health insurance.
- Get equipment and supplies you do not need.
- Get care or drugs using some other person's ID.
- Give wrong symptoms to get treatment, drugs and other care.
- Have too many ER visits for problems that are not an emergency.
- Lie about your eligibility for Medicaid.

If you are proven to have misused your benefits, you might:

- Have to pay back money that was paid for care that was misused.
- Be charged with a crime and go to jail.
- Lose your Medicaid benefits.

Words to Know

Fraud – the purposeful misuse of or for gain of benefits.

Waste – using more benefits than what is needed.

Abuse – an action that causes unneeded costs to CareSource.

Please report fraud, waste, or abuse:

1. Call **1-844-415-1272** (TTY: 711).
2. Fill out the Fraud, Waste and Abuse Reporting Form. It is at **CareSource.com**. Choose *Forms* under *Member*. We can also mail you a printed copy.
3. Write a letter to:
   CareSource
   Attn: Program Integrity
   P.O. Box 1940
   Dayton, OH 45401-1940
4. Email **fraud@CareSource.com**.
5. Fax the form or other information to 1-800-418-0248.

You do not have to give us your name when you write or call. If you are not worried about giving your name, you may also send an email or fax. Please give us as many facts as you can. Add names and phone numbers. If we do not get your name, we will not be able to call you back for more information. What you share will be kept private as allowed by law.

Others may read your email without you knowing or saying it is okay if your email is not secure. Please do not use email to send a member ID number, social security number or any health information. Please use the form or phone number above. This can help protect your privacy.

You can also report directly to the state of Ohio by using one of the methods below:

- ✓ Ohio Department of Medicaid (ODM)
  Phone: 1-614-466-0722
  Online: https://medicaid.ohio.gov/stakeholders-and-partners/helpfullinks/reporting-suspected-medicaid-fraud?adlt=strict
- ✓ Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU)
  Phone: 1-800-642-2873
  Online: https://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud
- ✓ The Ohio Auditor of State (AOS)
  Phone: 1-866-FRAUD-OH
  Email: fraudohio@ohioauditor.gov

ADVANCE DIRECTIVES

An advance directive is a written record about your future care and treatment. This includes mental health care. It helps your family and providers know your wishes about your care. Some people may not want to spend months or years on life support. Others may want all steps taken to live longer.

You have a choice.
You do not have to make an advance directive, but we suggest you do. It will ensure your wishes are followed when you are not able to be consulted. It is best to make them while you are healthy. Providers must make it clear that you have a right to state your wishes about your health care. They must ask if your wishes are in writing. They also must add your advance directive to your medical record.

You will need to answer some tough questions when you make an advance directive. Think about these things when you make yours:

- It is a choice to write one.
- The law states that you can make choices about health care and surgical treatment, such as agreeing to or refusing care.
- Having one does not mean you want to die.
- You can choose a person to make health care choices for you when you cannot make them. You may also use it to keep certain people from making decisions for you.
- You must be of sound mind to make one.
- You must be at least 18 years old or an emancipated minor to have one.
- Having one will not change other insurance.
- They can be changed or ended at any time.

Advance directives should be kept in a safe place. Copies should be given to your family, health care agent and providers.

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 Health Care Power of Attorney 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 provider 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.

Do I need a lawyer?
No, you don't need a lawyer to fill out an advance directive. You may want to speak with a lawyer for help.

Do the people giving medical care have to follow my wishes?
Yes, if your wishes follow state law. Ohio law has a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against their conscience. If so, they will help you find someone else who will follow your wishes. If you have any concerns about someone not following your wishes, you may file a complaint with the Ohio Department of Health.

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. 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?
If you are in terminal condition or a permanently unconscious state, then Ohio law recognizes an order of decision makers if you are unable to make health care decisions for yourself and you do not have an advance directive. Ohio law recognizes this order of your decision makers: legal guardian, spouse, majority of adult children, parents, and other nearest relative.

Where do I get advance directive forms?
Many of the people and places that give you medical care have advance directive forms. A lawyer could also help you.

What do I do with my forms after filling them out?
You should give copies to your provider 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 Health Care Power of Attorney, 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.

What is a guardian?
A guardian is someone chosen by a court to be legally in charge for another person.

When will a guardian be chosen?
A court will choose a guardian for someone who can no longer make safe choices by themselves. This is usually due to legal or mental incapacity. In certain situations a minor may also have a guardian chosen for them.

How do I get a guardianship?
Only a court can choose a guardian. The court that chooses a guardian is your local court.
This could differ based on where you live. Call your local court, a local lawyer, or local legal aid service for more information.

ESTATE RECOVERY

If you are permanently institutionalized or age 55 or older when you receive Medicaid benefits, the Estate Recovery Program may recover payments for the cost of your care paid by Medicaid from your estate. The cost of your care may include the capitation payment that Medicaid pays to your managed care plan, even if the capitation payment is greater than the cost of the services you received. **Estate Recovery only happens after the death of the Medicaid recipient.**

The state recovers the cost of care they paid by Medicaid from the property and personal belongings you own or have at the time of your death. It could be a home, savings and checking accounts, cars, jewelry, cash or more. By law, this takes place after your death and:

- After the death of your surviving spouse
- If there are no surviving children under the age of 21
- If there are no surviving children of any age who are blind or disabled

Each situation is different. Contact a legal professional to learn more about the estate recovery process.

QUALITY IMPROVEMENT PROGRAM

We work to make sure that the care and services you get are the best they can be. We want you to be happy with your care. We use evidence-based measures and tools to see how well we are keeping you healthy. Examples of this include:

- Well-child care
  - Making sure children see their PCP on a routine basis
  - Making sure children get their shots
- Preventive screenings
  - Breast cancer screening (mammogram)
  - Colon cancer screening (colonoscopy)
  - Cervical cancer screening (Pap test)
  - Prostate cancer screening
- Prenatal and postpartum care
  - Making sure you see a provider as soon as you know you're pregnant
  - Making sure you see the provider after you have a baby
- Long-term health problems such as:
  - Asthma:
    - Routine use of inhalers
  - Diabetes:
    - Routine tests for blood sugar numbers over three-month period, called an A1C
    - Testing how well your kidneys are working
    - Checking your eyes each year, called a diabetic retinal exam
    - Checking your feet
  - High blood pressure
    - Making sure you take blood pressure drugs
    - Making sure you check blood pressure numbers based on your provider's orders
- Encouraging you to see your provider after being in the hospital for your mental health
- Making sure children who take medication for attention deficit hyperactivity disorder (ADHD) see their provider on a routine basis.

We also look at how quickly you get care and if you got the care you needed. And we make sure you get good service from CareSource.

Health Guidelines and Resources

Health guidelines help us take the best care of you and your family. These rules are based on your age and health issues you may have. CareSource uses the same health guidelines used by providers across the country to help you stay healthy. These guidelines make sure that you get the health screenings and exams you need. You can view these guidelines and learn more at **CareSource.com**. A printed copy of the guidelines can be mailed to you if you ask for them.

CareSource may also call or send you reminders on health exams and screenings you may need. If you have a long-term health issue like asthma or diabetes, you should:

- See your PCP on a regular basis.
- Talk with your PCP about the best plan to take care of your health issue or if you have trouble following the plan you made with your PCP.
- Take the medications your PCP has given you.
- Call your provider to talk about changing your medications if they make you sick or cause an allergic reaction.
    - Don't stop taking your medication until you talk to your provider.

To learn more about CareSource Quality Improvement, please call Member Services.

MEDICAID ELIGIBILITY AND OTHER HEALTH INSURANCE

Accidental Injury or Illness (Subrogation)

If you have to see a doctor for an injury or illness that was caused by another person or business, you must call Member Services 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, another insurance company may have to pay for the care or services you received. When you call us give the name of the person at fault, their insurance company and the name(s) of any attorney(s) involved.

Other Health Insurance (Coordination of Benefits – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call Member Services 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, you need to call Member Services. It is also important to tell Member Services and your county caseworker if you have lost health insurance that you previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills. Keep in mind:

- If you have other insurance, they need to pay before we will pay for care. The other insurance must be billed before a claim can be sent to us.
- The provider will need both CareSource and the other insurance information when you get care.
- You must have both insurance cards on hand to get care.

Loss of Insurance Notice

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company. This notice says you no longer have insurance. 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 happened, CareSource would be told to stop your membership as a Medicaid member and you would no longer be covered by CareSource.

Automatic Renewal of MCO Membership

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become a CareSource member again.

MEMBERSHIP TERMINATIONS

We hope you are happy with CareSource. Please let us know if you have any issues or concerns so we can try to resolve them.

Ending Your CareSource Membership

As a member of a managed care organization (MCO), 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. The Ohio Department of Medicaid will notify you to tell you when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care organization to cover your health care services.

If you want to end your membership during the first three months of your membership or during the annual open enrollment month, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 711). You can also submit a request online by visiting the Medicaid Hotline website at www.ohiomh.com. 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 organization, your new managed care organization 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 managed care organization (MCO), you should learn about your choices. Especially if you want to keep your current provider(s). Remember, each MCO has its own list of doctors and hospitals that are in the network. Each MCO also has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care organization you are thinking of joining or if you simply have questions about the MCO, 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 MCOs 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 membership with a plan. This is called a "just cause" membership termination. Just cause requests apply to periods outside of open enrollment and the first three months of enrollment. To ask for a just cause membership termination, you may first call CareSource and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a just cause termination if you have one of the following reasons:

1. You move and your current MCO is not available where you now live, and you need non-emergency medical care in your new area before your MCO membership ends.
2. Your current MCO 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 the services are not all in the MCO's network.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider in the CareSource network.
5. You do not have access to medically necessary Medicaid-covered services or do not have 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 in the CareSource network and that was the only in-network PCP who spoke your language and was located within a reasonable distance from you; or another plan has a PCP in their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. If you think staying as a member in your current managed care plan is harmful to you and not in your best interest.

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 will review your request 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 your membership ends. If you live in a mandatory enrollment area, you will have to choose another plan 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 MCP 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 CareSource 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 card and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new MCO and have any medical visits scheduled, call your new plan to be sure that these providers are in the new plan's provider network and that 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

You have the option not to be a member of a managed care organization (MCO) if:

- You are a member of a federally recognized Indian tribe, regardless of your age.
- You are an individual who receives home- and community- based waiver services through the Ohio Department of Developmental Disabilities.

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care organization, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If you meet the above criteria and do not want to be an MCO member, your MCO membership will be ended.

Exclusions – Individuals That Are Not Permitted to Join a Medicaid MCO:

You may not be allowed to join a Medicaid managed care organization (MCO) if you are:

- Dually eligible under both the Medicaid and Medicare programs;
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID), or some other kind of institution); or
- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.*

**If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Organization. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Organization.*

If you believe that you meet any of the above criteria and should not be a member of a managed care organization, you must call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If you meet the above criteria, your MCO 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 the MCO'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
Office of Managed Care
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709

Phone: 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.

You can contact CareSource to get any other information you want including the structure and operation of CareSource and how we pay our providers. If you want to tell us about things you think we should change, call Member Services at **1-800-488-0134** (TTY: 711).

RENEWING YOUR MEDICAID BENEFITS

Redetermination

Redetermination is when you renew your Medicaid coverage. Some people need to renew their Medicaid coverage each year so that they can keep their health coverage. CareSource cannot renew for you. You need to renew through your local County Department of Job and Family Services (CDJFS).

Visit **CareSource.com/RenewOHMed** to find helpful hits and tips to make sure you are ready to renew.

If you need to renew, you will get a letter or packet in the mail from CDJFS about your Medicaid eligibility. Make sure they have your updated contact information so that you can get this mail on time. Respond to any mail you get from CDJFS as soon as you can.

Renew in one of these ways:

- **ONLINE:** Go to benefits.ohio.gov if you have an online account. Log in and choose Renew My Benefits.
- **BY PHONE:** Call the CDJFS call center at 1-844-640-6446 (TTY: 711). You can call Monday through Friday, 8 a.m. to 4 p.m.
- **IN PERSON:** Some offices let you come in person to get help. Check with your County Department of Job and Family Services to see if you can come in person.

We want you to stay a CareSource member!

WORD MEANINGS

Managed Care Terminology

Abuse: An action that causes unneeded costs.

Advance directives: A written record about your future care and treatment.

Appeal: Asking us to review a decision that denied a benefit or service. Or, a member's request for CareSource to review an adverse benefit determination.

Appointment: A visit you set up to see a provider.

Assertive Community Treatment (ACT): A team-based style of mental health care. It offers tailored care if you have a severe mental health condition. ACT teams can help with your medication and teach you skills to reach your goals. ACT gives you flexibility with when and where you get services.

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

Behavioral health services: Preventing, diagnosing and treating mental health and substance use disorder issues.

Benefits: Your covered health care services. Benefits are also the extra programs and services that you get through CareSource.

Business days: Monday through Friday, 7 a.m. to 8 p.m. except for holidays.

Calendar days: Each day of the week, along with weekends and holidays.

Care management: A team of registered nurses, social workers, and other outreach workers who work with you, your PCP and/or other specialists, and any family or other caregivers you would like to help coordinate your care.

Chronic condition: A problem that affects your health for a long period of time.

Claim: An ask for a benefit made by you or your provider for services you think are covered. This includes a reimbursement if you have already paid for the service.

Co-payment: Part of the cost for care you must pay. Or, a fixed amount a member pays for a covered health care service.

Convenience care clinic: A health clinic in a retail or grocery store. These are often open late and open on weekends to care for routine sicknesses.

Covered services: Medically necessary care that we pay for.

Diagnostic: Tests to figure out what your health problem is.

Disenrollment: The removal of a member from CareSource.

Durable Medical Equipment (DME): Supplies that can be used more than once for health services. Or, equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

Emergency medical condition: An illness, injury, symptom, or condition that needs immediate care. Or, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency medical transportation: transportation, by ambulance, of sick, injured or otherwise incapacitated persons who require emergency medical care.

Emergency room care: Care you get for life-threatening issues that must be treated immediately. Or, medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care treatment or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Emergency services: Services that are needed to check, treat or stabilize an emergency medical condition. Or, covered inpatient services, outpatient services, or medical transportation services that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition. Providers of emergency services also include physicians or other health care professionals or health care facilities not under employment or under contractual arrangement with CareSource.

EPSDT: Early and Periodic Screening, Diagnostic and Treatment. This is preventive care given to those under the age of 21.

Excluded services: Health services that CareSource does not pay for or cover.

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

Fraud: Misusing benefits on purpose.

Grievance: A complaint about us or our providers. Or, a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by an MCE to make an authorization decision.

Guardian: A person appointed by a court to be legally responsible for another person.

Habilitation services and devices: Health care that helps you keep, learn, or fix skills and functioning for daily living. Or, services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings.

Health care services: Preventive or diagnostic treatments that are linked to your health.

Health insurance: A contract that requires CareSource to pay or all of your covered health care costs in exchange for a premium.

Home health care: The medical and health services that are given in your home by a provider. Or, services that include home health nursing, home health aide services and skilled therapies.

Hospice services: Services that give comfort and support for a person in the last stages of a terminal illness. Or, a public agency, a private organization, or a subdivision of either, subject to the conditions of participation pursuant to 42 C.F.R. Part 418 (October 1, 2017), that is licensed in the state of Ohio and approved by the ODM to engaged in providing care to terminally ill individuals. (5160-56-01(V)).

Hospitalization: Care in a hospital where you are admitted as an inpatient.

Hospital outpatient care: Care in a hospital. It often includes an overnight stay. Or, diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to a patient by a hospital.

Medicaid: Federal health insurance for low-income families, children, pregnant women, people with disabilities and others.

Medically necessary: Care needed to diagnose or treat an illness, injury, condition, disease or its symptoms. Or, criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Mental health parity and addiction equity: Mental health and substance use disorder services are covered in the same way as physical conditions like diabetes.

Member: A person who is enrolled with CareSource and gets health care from our providers.

Network: CareSource's contracted providers available to CareSource's members.

Network provider or in-network provider: A doctor, hospital, pharmacy or other provider that gives care to CareSource members. The Find a Doctor online tool has the most up-to-date list of network providers near you.

Non-participating provider: An out-of-network provider or provider outside the CareSource network. Or, any provider with an ODM provider agreement who does not contract with CareSource but delivers health care services to CareSource's members.

Obstetricians/Gynecologists (OB/GYNs): Providers who care for the female reproductive organs.

ODM: Ohio Department of Medicaid.

Optometrists: Providers who care for your eyes and vision.

Outpatient care: A procedure that can be done without an overnight stay in the hospital.

Out-of-network provider: A doctor, hospital, pharmacy or other provider that has not signed a contract to give care to CareSource members. We will not pay for services from these providers unless it is an emergency, we have given prior authorization or you are getting family planning services.

Over-the-Counter (OTC) drug: A drug you can often buy without a prescription. Please use your Gainwell Member Handbook to find out what OTC drugs are covered.

Participating provider: An in-network provider or provider in the CareSource network. Or, any provider, group of providers, or entity that has a network provider contract with CareSource in accordance with rule 5160-26-05 of the Administrative Code and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of CareSource's provider agreement or contract with ODM.

Pharmacists: Providers who help with prescriptions and other medications.

Pharmacy: Where to go to get medications or prescriptions.

Physician services: Health care that a doctor gives or arranges. Or, "Practitioner of physician services": are physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse

practitioners or physician assistants. (5160-2-02(L)).

Plan: How your health care services are paid. Or, (S) "Managed care organization (MCO)" or "managed care plan (MCP)" means a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. (5160-26-01(S)).

Post-stabilization care services: Follow up care you receive once you are stable after an emergency. Or, covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R.422.113 to improve or resolve the member's condition.

Preauthorization: Approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you. Or, a decision by CareSource that a health care service, treatment plan, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency.

Preferred Drug List (PDL): A list of covered medicines.

Premium: "Premium" means the monthly payment amount per member to which the MCO is entitled as compensation for performing its obligations in accordance with Chapter 5160-26 of the Administrative Code and/or the provider agreement with ODM. (516026-01(NN))

Prescription drug coverage: Drugs covered by the Single Pharmacy Benefit Manager (SPBM) that are dispensed to members for the use in a patient's resident, including a nursing facility or intermediate care facility for individuals with intellectual disabilities.

Prescription: A provider's order for your medication.

Prescription drugs: Simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

Preventive care: Routine care like screenings and exams. You get this care to help stop a health problem from occurring.

Primary Care Physician or Provider (PCP): Who you choose to be your personal doctor. They will treat you for most of your health care needs. Or, an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Ohio Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of rule 5160-4-03 of the Ohio Administrative Code contracting with CareSource to provide services as specified in rule 5160-26-03.1 of the Ohio Administrative Code.

Prior authorization: Approval that may be needed before you get a service. The service must be medically necessary for your care. Your provider will take care of this for you.

Provider: A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care-related services rendered to CareSource members.

Provider directory: A list of providers in the CareSource network. The Find a Doctor online tool has the most up-to-date list of providers near you.

Psychologists: Trained experts in mental health care. They do not write orders for medicine.

Psychotherapy: When you talk about your feelings, moods or thoughts with a licensed counselor or

therapist. You may learn skills to change behaviors, help your relationships with others and handle symptoms. These sessions can be one-on-one or with loved ones. This is also known as counseling or talk therapy.

Referral: A written order from your provider for you to see a specialist or get certain health care.

Rehabilitation services and devices: Help you keep, get back, or improve skills and functioning for daily life. The skills may have been lost or harmed because you were sick, hurt or disabled. Or, specific tasks that must, in accordance with Title 47 of the Ohio Revised Code, be provided directly by a licensed or other appropriately certified technical or professional health care personnel.

Schedule: To set up a time for a future visit.

Screening: A test done to spot health issues or diseases.

Service Areas: Where CareSource has coverage for members. We cover all of Ohio.

Skilled nursing care: Care from licensed nurses in your own home or in a nursing home. Or, specific tasks that must, in accordance with Chapter 4723 of the Ohio Revised Code, be provided by a licensed practical nurse (LPN) at the direction of a registered nurse or by a registered nurse directly.

SPBM: Single Pharmacy Benefit Manager. For Ohio Medicaid, this is Gainwell. Please refer to your Gainwell Member Handbook and website to learn more.

Specialist: A doctor who focuses on a certain kind of medicine or has special training in a certain type of health care. Or, a physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Substance use: Harmful use of substances, like alcohol and illegal drugs.

Symptom: Something that you feel, see or hear that could be a sign of an injury or illness.

Telehealth: A visit with a provider using a phone or computer.

Transcranial Magnetic Stimulation (TMS): TMS uses magnets to stimulate nerve cells in your brain. This can help improve symptoms of depression. TMS most often takes place in an office or outpatient setting.

Urgent care: Place to get care for an injury or sickness that needs to be treated right away. It is for mostly not life-threatening issues. Or, care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Utilization management: A review of care you get to make sure it works and is needed.

Waste: Using more benefits than what is needed.

APPENDIX

Ohio Single Pharmacy Benefit Manager (SPBM)

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1.1 Corporate Identity

Gainwell Technologies is a company with over 50 years of proven experience, and a reputation for service excellence and unparalleled expertise. Gainwell does not operate under any other trade names or DBA. At Gainwell, everything we do focuses on people.

The mission at Gainwell is to empower clients through innovative technologies and solutions to deliver great health and human services outcomes.

You are now a member of our Single Pharmacy Benefits Manager (SPBM). Here at Gainwell, we believe you deserve quality pharmacy services and should receive the most up-to-date services that we can provide.

Online: https://spbm.medicaid.ohio.gov

Email: OH_MCD_PBM@gainwelltechnologies.com

If you suspect provider or consumer fraud, please contact our Fraud, Waste, and Abuse toll free tip line at **1-833-491-0344 (TTY 1-833-655-2437)** and select the option to report Fraud, Waste, and Abuse concerns.

1.2 Available Services

Gainwell covers all Medicaid-covered, medically necessary prescription and over-the-count (OTC) medications. We use a preferred drug list (PDL) which is a list of drugs we prefer your provider prescribe. We may require your prescriber to submit a prior authorization request, which is where your prescriber would provide us additional information explaining why a specific medication and/or a certain dose or quantity of medication may be required.

The below services are available to you to support any additional needs you may have:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in alternative formats including braille and large print.

1.2.1 Preferred Drug List (PDL)

Gainwell uses a PDL which is a list of drugs we prefer your provider prescribes. You can find a copy of the PDL in the following locations:

- Under the Reference Material tab at: https://spbm.medicaid.ohio.gov
- Logging in to your Gainwell Member Portal at: https://spbm.medicaid.ohio.gov
- The Ohio Department of Medicaid pharmacy website at: https://medicaid.ohio.gov/stakeholders-and-partners/phm/unified-pdl
- A paper copy can be requested by calling Member Services at **1-833-491-0344 (TTY 1-833-655-2437)**

1.2.2 Prior Authorizations

Your prescriber may be required to submit a prior authorization request for certain medications. Gainwell accepts prior authorization submissions via phone, fax, mail, web portal, or ePA. In these circumstances, your provider will send an authorization request to the Gainwell Pharmacy Services team, where they will complete a clinical review of the medication your provider is requesting. Gainwell Pharmacy Services team will work closely with your prescriber to provide the best clinical decision. You will receive a letter in the mail with the outcome of the decision made.

If you do not agree with the decision that is made by Gainwell, you will be sent detailed information on how you can appeal the decision.

You have the option to call Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437) to obtain information regarding the PDL, medications that may require prior authorization, or to ask any medication related questions you may have. The PDL and a list of medications that require prior authorization are available for you to access online at: https://spbm.medicaid.ohio.gov. It is important that you and/or your prescriber reference the PDL and/or the list of medications that require prior authorizations each time you have questions, as these are documents that can change.

1.2.3 Pharmacy Utilization Management Strategies

The PDL will be used with each prior authorization review that is completed by the Gainwell Pharmacy Services team. When a prior authorization is required, Gainwell must approve the prescriber's request before you will be able to fill your medication at your preferred, in-network pharmacy. A prior authorization may be required if:

- A generic drug is available.
- The requested drug can be misused/abused.
- Other medications must be tried first.
- Quantity limits for the requested medication have been exceeded.
- The medication your provider has prescribed is not included on the PDL.

The PDL usually includes multiple medication options for treating a particular condition. These different drugs are referred to as "alternative" drugs and are just as effective as other drugs with no additional side effects or health problems.

Specific reasons your prescriber may be required to submit a prior authorization request include:

Step Therapy – In some cases, our plan requires you first try certain drugs to treat your medical condition.

Generic Substitution – This is where a pharmacy will be required to provide a generic drug in place of a brand-name drug when available. Generic drugs are just as safe and effective as brand name drugs and should be prescribed first.

Therapeutic Interchange – This is where you are unable to take a medication for reasons like an allergy, intolerance, etc., a medication might not work for you and your prescriber may write a prescription for a medication that is not on the approved drug list.

Specialty Medications – This is a review of a medication that is considered more complex for a specific disease and requires specific attention and handling during the prior authorization review process. For these medications, you may have to get them through a specialty pharmacy. Your prescriber will work with Gainwell Pharmacy Services to make sure you can obtain the medication you need as quickly as possible.

1.2.4 Excluded Services

Gainwell will not pay for the following categories that are not covered by the Ohio Medicaid pharmacy program:

- Drugs for treatment of obesity.
- Drugs for treatment of infertility.
- Drugs for the treatment of erectile dysfunction.
- DESI drugs or drugs that may have been determined to be identical, similar, or related.
- Drugs that are eligible to be covered by Medicare Part D.
- Over-the-counter drugs that are not listed in accordance with paragraph C of OAC rule 5160-9-03.
- Drugs being used for indications not approved by the Food and Drug Administration (FDA) unless supported by compelling clinical evidence.

1.2.5 Additional Services

The Gainwell Pharmacy team can also assist you with the below services by calling our member help desk at **1-833-491-0344 (TTY 1-833-655-2437)**. You can also access this information on your member portal by logging in at https://spbm.medicaid.ohio.gov.

- Locating a pharmacy to fill the prescription you were given by your provider.
- Verifying you have active pharmacy coverage.
- Obtaining diabetic supplies covered through your pharmacy benefit.
- Obtaining durable medical equipment (DME) covered through your pharmacy benefit.

1.3 Requests for Appeals, Grievances, or State Hearings

Grievance

If you are unhappy with anything in relation to Gainwell Pharmacy Services or our providers, please contact us as soon as possible. This is called a grievance.

To contact us you can:

- Call Member Services at **1-833-491-0344 (TTY 1-833-655-2437)** and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below or online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter telling us you are unhappy. Please be sure to include your first and last name, your Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail: Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

Once you contact Gainwell to submit your grievance, we will follow up with you by telephone, mail delivery, or other appropriate means with the below timeframes:

- Two (2) working days for grievances about not being able to get medications you need.
- Thirty (30) calendar days for all other grievances.

Appeal

If you receive a notice from us that you disagree with, you may ask for an appeal within sixty (60) calendar days after the date of the notice. Gainwell will provide you with an answer to your appeal within fifteen (15) calendar days from the date you contacted us. If you believe fifteen (15) calendar days could seriously

jeopardize your life, physical or mental health or ability to attain, maintain, or regain maximum function, contact Gainwell Member Services at the number listed below as soon as possible to expedite your review process. To request an appeal, you can:

- Call Member Services at 1-833-491-0344 (TTY 1-833-655-2437) and choose option 1 to speak with a Gainwell Pharmacy Help Desk team member.
- Fill out the Grievance/Appeal form included in this member handbook and mail to Gainwell Pharmacy Services at the address below, or complete online through your member portal.
- Visit our website at https://spbm.medicaid.ohio.gov.
- Write a letter. Please be sure to include your first and last name, Medicaid ID, your address, and your telephone number so we are able to contact you, if needed. You can submit your form or letter via email or mail.

Email: OH_MCD_PBM@gainwelltechnologies.com

Mail: Gainwell Pharmacy Services
5475 Rings Rd.
Atrium II North Tower, Suite 125
Dublin, OH 43017-7565

When submitting an appeal, please include the following information:

- Your name and Medicaid ID number on your card.
- Your prescriber's name.
- The reason you disagree with the outcome provided by Gainwell.
- Any documentation or information to support your request to have your decision overturned.

Gainwell must provide you with an answer to your appeal within fifteen (15) calendar days from the date you contact us. If we do not change our decision, you will be notified in writing and will be provided your right to request a State hearing. You must complete the appeal process before you are able to request a State hearing.

If we need more time to make a decision for either a grievance or appeal, we will send you a letter telling you we need to take up to fourteen (14) more calendar days. That letter will also provide you with information as to why we need more time to complete your request.

State Hearing

You must complete the Gainwell appeal process before you are able to request a State hearing. A State hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from Gainwell, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). During this meeting, you will explain why you think Gainwell Pharmacy Services did not make the right decisions and Gainwell will explain the reasons for making our decision. A decision will be made by the hearing officer based on rules, regulations, and information provided during the hearing.

You will be notified of your right to request a State hearing if we do not change our decision as a result of appeal to Gainwell. If you would like to request a State hearing, you or an authorized representative must request a hearing within ninety (90) calendar days of your denied appeal from Gainwell.

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 (TTY/TDD 614-728-2985), or submit your request via email to bsh@jfs.ohio.gov. If you want information on free legal services, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number to your legal aid office.

State hearing decisions are usually issued no later than seventy (70) calendar days after the request is received. If it is determined 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 (3) business days after the request is received. Expedited decisions are for situations when the standard review time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

1.4 Change Recommendations

As a member of Gainwell Pharmacy Services, you have a membership right to make recommendations regarding rights and responsibilities surrounding medication coverage.

Recommendations can be emailed to Gainwell Pharmacy Services as OH_MCD_PBM@gainwelltechnologies.com or call Member Services at **1-833-491-0344 (TTY/TDD 614-728-2985)**.

1.5 Pharmacy Access

Gainwell Pharmacy Services offers a member portal for you to log in and manage your pharmacy needs. To log in to your personal member portal, visit https://spbm.medicaid.ohio.gov and log in with your personal information that you have set up for your account.

To sign up for an account through the Gainwell Member Portal, you can follow the directions on the website at https://spbm.medicaid.ohio.gov or call Member Services toll free at 1-833-491-0344 (TTY 1-833-655-2437) to speak with a Gainwell Pharmacy Services agent to receive step-by-step assistance to sign up for access.

1.6 Emergency Outpatient Drug

In the event of an emergency situation, you will have the option to receive a 72-hour (3 day) supply of your medically necessary medication. If you have difficulties with this process, please contact Gainwell Pharmacy Services at 1-833-491-0344 (TTY 1-833-655-2437).

1.7 Non-Discrimination Statement

Gainwell Pharmacy Services follows State and Federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, gender, gender identity, sexual orientation, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, military status, veteran status, ancestry, the need for health services to receive any covered services or geographic location.

Gainwell has no moral or religious objections to services that we provide for Ohio Department of Medicaid members.

If you are in need of any additional services below, please contact Member Services toll free at **1-833-491-0344 (TTY 1-833-655-2437)** to speak to a team member at no additional charge:

- Oral interpretation.
- Translation services.
- Auxiliary aids and services.
- Written information in other languages, including, but not limited to, Spanish, Somali, and Arabic.
- Written information in alternative formats including, but not limited to, braille and large print.

1.8 Provider Network Statement

Gainwell works with pharmacies to fill prescriptions close to your home for easy access to any of your medication needs. Many of the pharmacies offer services including prescription home delivery, medication management and assistance if you have limited English, hearing or sight difficulties, or a disability needing extra support. Specialty pharmacies also are available to provide medications with specific handling, storage, and distribution requirements to treat high risk, complex, or rare disease (s). If there are any changes to these pharmacies, we will be sure to let you know via the website, Gainwell Member Portal, or mailings as determined by your preferred communication request.

Gainwell does not cover prescription fills at pharmacies that are not signed up (Out of Network) to dispense medications for Ohio Medicaid members, which includes, but is not limited to, pharmacies that are far away from your home, except for emergency situations (if out of the State in an emergency or if an Ohio pharmacy cannot supply the medication).

1.9 Pharmacy Provider Network

You can obtain information on how to locate a pharmacy covered in your network by accessing the Pharmacy Provider Directory online at https://spbm.medicaid.ohio.gov or through logging in to your Gainwell Member Portal at https://spbm.medicaid.ohio.gov. You can request a paper copy of the Pharmacy Provider Directory by calling Member Services toll free at **1-833-491-0344 (TTY 1-833-655-2437)**.

Member Standardized Appeal Form

Complete Sections I and II of the form entirely, describe the issue(s) in as much detail as possible, and submit it to CareSource. To ensure a decision can be made by CareSource, the following documentation should be submitted with the form:

- Attach copies of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I - Member Information	
Member Name:	**Date of Birth (mm/dd/yyyy):**
Member ID Number:	**Member Phone Number.**
Member Address:	
Date of Request (mm/dd/yyyy):	**Request Type:** ☐ **Grievance/Complaint** ☐ **Appeal**

Section II - Description of Specific Issue Please state all details relating to your request including names, dates, and places. Attach another sheet of paper to this form if more space is needed.

By signing below, you agree that the information provided is true end correct. If someone else is completing this form for you, you are giving written consent for the person named above to submit on your behalf.

Member's Signature:	**Date (mm/dd/yyyy):**
Member's Authorized Representative Name (If applicable):	**Authorized Representative Signature (if applicable):**

CareSource®

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