Member Handbook

CareSource™
PASSE

ENGLISH - Language assistance services, free of charge, are available to you. Call: **1-833-230-2005** (TDD/TTY: 711).

CareSource PASSE

SPANISH - Servicios gratuitos de asistencia lingüística, sin cargo, disponibles para usted. Llame al: 1-833-230-2005 (TDD/TTY: 711).

NEPALI - तपाईंका निम्ति निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन् । फोन गर्नुहोस्: 1-833-230-2005 (TDD/TTY: 711).

KOREAN - 언어 지원 서비스가 무료로 제공됩니다. 전화: 1-833-230-2005 (TDD/TTY: 711).

FRENCH - Services d'aide linguistique offerts sans frais. Composez le 1-833-230-2005 (TDD/TTY: 711).

GERMAN - Es stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Anrufen unter: 1-833-230-2005 (TDD/TTY: 711).

SIMPLIFIED CHINESE - 可为您提供免费的语言协助服务。请致电：1-833-230-2005 (TDD/TTY: 711).

TELUGU - భాషా సాయం సర్వీసులు, మీకు ఉచితంగా లభ్యమవుతాయి. కాల్ చేయండి: 1-833-230-2005 (TDD/TTY: 711).

BURMESE - ဘာသာစကားဆိုင်ရာအကူအညီဝန်ဆောင်မှုများအား သင့်အတွက် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ရန်: 1-833-230-2005 (TDD/TTY: 711).

ARABIC - تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم: 1-833-230-2005 (هاتف نصيّ: 711).

URDU - زبان کی معاونتی ترجمانی خدمات، آپ کے لیے بالکل مفت یا فری آف چارج دستیاب ہیں۔ کال کریں: 1-833-230-2005 (TDD/TTY: 711).

PENNSYLVANIA DUTCH - Mir kenne dich Hilf griege mit Deitsch, unni as es dich ennich eppes koschte zellt. Ruf 1-833-230-2005 (TDD/TTY: 711) uff.

RUSSIAN - Вам доступны бесплатно услуги языкового сопровождения. Позвоните по номеру: 1-833-230-2005 (TDD/TTY: 711).

TAGALOG - May mga serbisyong tulong sa wika, na walang bayad, na magagamit mo. Tumawag sa: 1-833-230-2005 (TDD/TTY: 711).

VIETNAMESE - Dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi: 1-833-230-2005 (TDD/TTY: 711).

GUJARATI - ભાષા સહાય સેવાઓ તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-833-230-2005 (TDD/TTY: 711). પર કૉલ કરો.

PORTUGUESE - Serviços linguísticos gratuitos disponíveis para você. Ligue para: 1-833-230-2005 (TDD/TTY: 711).

MARSHALLESE - Jerbal in jibañ ikijen kajin, ejelok onean, ej bellok ñan eok. Kurlok: 1-833-230-2005 (TDD/TTY: 711).

NOTICE OF NON-DISCRIMINATION

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

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

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

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

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

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

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Have a health issue? Call our CareSource24 Nurse Advice Line at **1-833-687-7305** (TDD/TTY: 711). We are here 24/7. Find providers at **findadoctor.CareSource.com**.

TABLE OF CONTENTS

Welcome!

We are glad you are with us! Our mission is to deliver the dignified, innovative and accessible care that every Arkansan deserves. This is the heart of who we are.

Please look through this handbook. Keep it handy so you can look at it later. Call your care coordinator if you have any questions. You can also call Member Services. You can find the handbook on **CareSourcePASSE.com** under *Plan Documents*.

CareSource™
PASSE

CARE COORDINATION

Care Coordinator

Your care coordinator is your main point of contact. They will get to know you, your providers, and others who are part of your care. They will touch base with you at least once a month. You can connect more often if you would like. Your care coordinator will help you:

- ✓ Learn about your health and medications.
- ✓ Get the medical, home and community-based services, behavioral health and social services that you need.
- ✓ Get what you need to live and work in your community.
- ✓ Develop your Person-Centered Service Plan (PCSP) with your team.

Care coordinators help build strategies for your health care needs. This is more than just visits with providers. They care for you as a whole person. They will give you resources and advice on issues you face each day.

Our care coordination team will reach out to you within the first 15 days that you join CareSource PASSE. Please call Member Services if you have not heard from them in that time. You can also reach the care coordination team 24/7 through the CareSource24® Nurse Advice Line.

Person-Centered Team

Your Person-Centered Team (PCT) is built around you. You choose who is part of your PCT. Your PCT can be made up of your family or caregivers, friends, your specialists, and your primary care, behavioral health, waiver and home health providers. You are in the driver's seat. Your PCT will work with you to develop your PCSP.

Person-Centered Service Plan

Your care coordinator will work with you and your PCT to make a PCSP. This is an overall plan of care. Your care coordinator will make sure you have what you need to meet your goals. They will keep track of all the services in your PCSP. They will help make changes as needed.

What is in your PCSP:

- What you need:
  - CareSource PASSE phone numbers.
  - Emergency phone numbers.
  - List of people on your PCT.
- What you and your PCT need:
  - Your diagnosis.
  - Your social, medical, physical and mental health history.
  - List of your medications.
  - List of services you get and who provides them.
- What your PCT needs to know to best help you:
  - Your treatment, goals and objectives for your care.
  - Your strengths, choices and preferences.
  - A crisis plan to help you through or even prevent a crisis.

Home and Community-Based Services

Home and community-based services help you stay at home and in your community instead of going to a nursing home, hospital, or other care facility. Your care coordinator can help you get any of these services.

They will:

- Set up all your waiver services and state plan services.
- Go over your needs to find medical, social and education services. They can also find support for your family.
- Make sure your services are keeping you healthy and safe.
- Make sure you can meet the goals in your PCSP.
- Help you get legal aid if you would like it.
- Help you renew or change your care or health coverage.
- Help you get immediate care if you are in emotional, mental or physical distress.

You have a right to get these services in places that:

- You choose to live. This could be residential or day options. This includes non-disability settings.
- Give you full access to and be part of the greater community.
- Let you make your own life choices.
- Ensure your right to privacy, dignity, respect, and freedom from coercion and restraint.
- Let you find an integrated job.
- Let you choose services and who provides them.
- Are physically accessible to you.

If where you live is owned or controlled by a provider of your home and community-based services, you also have a right to:

- A lease or other legal agreement that protects you from eviction.
- Privacy in your bedroom with entrances that you can lock. Staff may have keys as needed.
- A private unit or choice of roommates.
- Furnish and decorate your unit how you want to.
- Have control over your own schedule.
- Have access to food at any time.
- Have visitors of your choice at any time.

CONTACT US

Member Services

Phone:	**1-833-230-2005** (TDD/TTY: 711) Open Monday through Friday from 8 a.m. to 5 p.m. Central Time.
Mailing Address:	CareSource PASSE P.O. Box 8730 Dayton, OH 45401-8730
Online:	**CareSourcePASSE.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 an in-network provider.
- Change your address, phone number or email.
- File a complaint against us or a provider or if you think you have been discriminated against.

We are closed* in 2024 on these days:

- January 1
- January 15
- May 27
- July 4
- September 2
- November 28 and 29
- December 24 and 25
- September 2

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

Accommodations

Are you or someone you care for a CareSource PASSE 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.

CareSource24 Nurse Advice Line

Phone: **1-833-687-7305** (TDD/TTY: 711)

You can call us 24 hours a day, 7 days a week, 365 days a year. This is a free call. We can help you:

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

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.

CareSource PASSE Mobile App

Manage your plan on the go! The app uses multi-factor authentication to keep your data safe. With the mobile app you can:

- Access your My CareSource account.
- View your digital ID card.
- Find a provider, hospital, clinic, or urgent care near you through the *Find A Doctor* tool.
- Call and speak with Member Services or CareSource24.
- View your claims, and more!

Manage your plan on the go! The app uses multi-factor authentication to keep your data safe.

Get the mobile app through the App Store® for iPhone® or Google Play® for Android®.

CONSUMER ADVISORY COUNCIL

The Consumer Advisory Council (CAC) meets on a routine basis. It is made up of members, parents, guardians and advocates. The CAC goes over topics and gives feedback. It also lets us hear how we can work to be a better PASSE. Please call Member Services or email **CAC@CareSourcePASSE.com** to ask to join.

PASSE OMBUDSMAN

A PASSE Ombudsman is someone who will help you when:

- You need help solving a problem with CareSource PASSE.
- You think you are not getting the care you need.
- You feel that your rights are violated.

The PASSE Ombudsman is part of the Arkansas Department of Human Services. It is not part of CareSource PASSE. You can reach the PASSE Ombudsman in four ways:

Phone:	1-844-843-7351 (TTY/TDD: 1-888-987-1200, option 2)
Email:	**PASSEombudsmanOffice@dhs.arkansas.gov**
Mail:	Division of Medical Services Office of the Ombudsman P.O. Box 1437 Slot S-418 Little Rock, AR 72203-1437
Fax:	501-404-4625

MEMBER ID CARDS

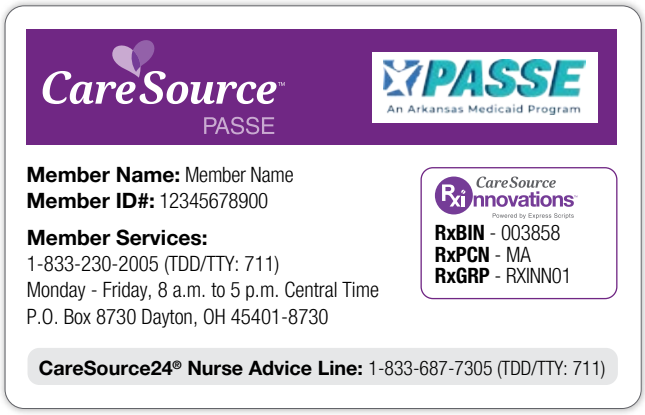
Your member ID card comes in the mail with the New Member Booklet when you first enroll in CareSource PASSE. Please call Member Services if you did not get yours in the mail.

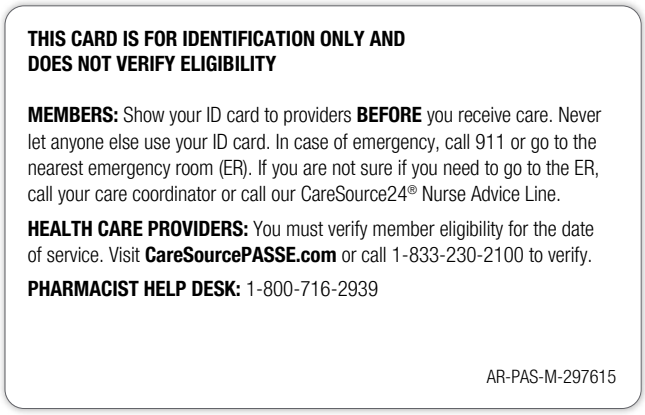
- Each CareSource PASSE member will get their own ID card.
- Each ID card is good while you are a member. Cards do not expire.
- You can view your digital ID card in the mobile app or at **MyCareSource.com**.
- You can order a new card at **MyCareSource.com**. You can also call Member Services and ask that a new one be mailed to you.

Call Member Services if:

- You did not get your ID card in the mail.
- Any of the information on the card is wrong.
- You lose your card.
- You have a baby.

Member ID cards will look like the one below





Always keep your ID card with you. You will need your card when you:

- Visit a provider or a specialist.
- Go to the ER or a hospital.
- Go to urgent care.
- Get medical supplies.
- Pick up a prescription.
- Have medical tests.

CURRENT TREATMENT PLANS AND HEALTH CARE

Continuity of Care

If you change to CareSource PASSE from Medicaid or another PASSE, we will work with you to keep getting your current care without disruption. We can also help if:

- You are new to CareSource PASSE.
- Your provider has left the network.
- You leave us to go to another PASSE.
- You transfer to Medicaid.
- You transfer between settings like an inpatient hospital back to your home or community.

If you are new to CareSource PASSE:

- Your ongoing care may need to be approved before you get it. Call Member Services first unless it is an emergency.
- The prescriptions you take may need to be approved before you fill it. Talk with your care coordinator or call Member Services to find out if you need to get approval.
- We will help you find a provider in the CareSource PASSE network. You can also find providers near you at **findadoctor.CareSource.com**.

Direct Access to Specialist Care: Standing Referral

If you need ongoing care, you can see a specialist with a standing referral. The care must be right for your health issue and needs.

EXPLANATION OF BENEFITS

When you visit a provider or have health care services, we sometimes send an Explanation of Benefits (EOB). An EOB is **not a bill**. It will list:

- Who got care.
- The provider who billed for the care.
- The date of the care.
- The type of care.
- The amount that we paid.
- How much you owe or already paid.

Please call Member Services if you do get a bill.

PAYMENT RESPONSIBILITY

You will not be billed for PASSE-covered services. Make sure that the care you get is covered. If your provider says you need a service that is not covered, you may have to pay if you choose to get it. Talk to your care coordinator or call Member Services. There may be other providers or comparable services you can get.

Other Insurance

Let us know if you have other insurance. This would be if you are on a family member's plan or if your children are covered by another parent or guardian.

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 PASSE and the other insurance information when you get care.
- You must have both insurance cards on hand to get care.

If you have Medicare:

- Your prescriptions are covered by Medicare Part D.
- Medicare is your primary coverage. CareSource PASSE is secondary.
- You do not have to choose a PCP through CareSource PASSE.
- Please work with your care coordinator. They can help you work through Medicare and through CareSource PASSE.

SERVICES COVERED BY CARESOURCE PASSE

We cover all medically necessary care. This includes:

- Ambulance services.
- Behavioral health services.
- ER services.
- Helping you plan for having children.
- Home and community-based services.
- Inpatient and outpatient care.
- Maternity care.
- Office visits for primary care and specialists.
- Preventive care.
- Vision care.
- Well-baby or well-child visits.

Services Covered by Medicaid

Medicaid covers services that we do not cover. They are:

- Assisted living facility services.
- Dental benefits in a capitated program.
- Human Development Center (HDC) services.
- Nonemergency Medical Transportation (NEMT).
- School-based services given by school staff.
- Skilled nursing facility services (not a limited rehabilitation stay).
- Transplants.
- Transportation to and from Early Intervention Day Treatment (EIDT) and Adult Development Day Treatment (ADDT).
- Waiver services for the elderly and adults with physical disabilities. This is through the ARChoices in Homecare program, the Arkansas Independent Choices program or a successor waiver.

Talk to your care coordinator if you need help getting any of these services.

Services Outside of Our Network

Some services will need to be approved before you can get them. Learn more about prior authorization and referrals on the next page. You can also find out what needs approval in the covered services chart on **page 13**.

Words to Know

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

Covered Service – medically necessary care that we pay for.

Prior Authorization and Referrals

Prior Authorization is the approval that may be needed before you get a service. It must be medically necessary for your care. Your provider will get approval for the care you need.

Services that need prior authorization are noted in the chart on **page 13**. A full list of can be found at **CareSourcePASSE.com**. Click *Plans* and then choose *Benefits* to find the full list. You can also call Member Services to learn more.

You may need a referral to see a specialist or get certain care. This means that your provider will order these services for you before you get them. They will either call and arrange it for you, give you a written note, or tell you what to do.

Words to Know

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.

Please Note:

- You should get care from providers in our network. Network or in-network means that these providers have signed a contract and have agreed to see our members. Your care coordinator or Member Services can help you find a provider in our network. You can also visit **findadoctor.CareSource.com** to find one near you.
- If you see a provider who is not in our network, you need prior authorization except if it is an emergency.

Covered Services Chart

This chart goes over the care that is covered under your plan. There may be times when services are limited after you use so many of them. Limits are noted in the chart. If prior authorization is needed, it will be noted. Work with your care coordinator or call Member Services if you have any questions.

Service	More Information	Requirements
Allergy Testing and Treatment	Allergy testing is covered for all ages. Treatment is covered for ages 20 and under.	
Ambulance and Air Ambulance	Taking an ambulance or an air ambulance is covered for emergencies. An ambulance to a doctor's office or clinic is covered under certain conditions. Ambulette and wheelchair vans are not covered.	

Service	More Information	Requirements
Behavioral Health and Substance Use Disorder Services	If you need behavioral health and/or substance use disorder services, please find a provider at **findadoctor.CareSource.com** or by calling Member Services. You can also talk to your care coordinator to learn more. If you need help right away, call 911 or 988.	These services need prior authorization. Some only need it once you have met your benefit limit: • Adaptive behavior treatment • Family psychotherapy (marital/family behavioral health counseling) • Group pharmacologic counseling • Individual pharmacologic counseling • Inpatient services • Psychiatric diagnostic evaluation (mental health diagnosis) • Psychiatric diagnostic evaluation with medical services (psychiatric assessment) • Psychosocial rehabilitative services • Psychotherapy (individual behavioral health counseling) • Therapeutic behavioral services (behavioral assistance)
Breast Cancer and Cervical Cancer Screenings	Breast cancer screenings (Mammograms) are covered. Cervical cancer screenings (Pap tests) are covered at one test each year.	
Certified Nurse Midwife (CNM)	Nurses who help you with pregnancy, labor and giving birth.	
Certified Nurse Practitioner (CNP)	Nurses who are trained in some of the medical care that doctors provide.	
Chiropractic Services	Involves adjustments to the spine or other parts of the body.	No limits for age 20 and under. Age 21 and older- 12 visits each year.

Service	More Information	Requirements
Colorectal Screening	Tests that look for signs of cancer in your colon and rectum. The Cologuard Lab Test is covered once every three years for ages 45 and older.	
Diabetes Screening	Tests to find out if you have high blood sugar. High blood sugar can put a person at risk for developing diabetes.	
Diagnostic Services	Lab work, x-rays or tests done to learn more about a specific condition or disease.	Prior authorization is needed for some bloodwork and lab testing once you have met certain benefit limits. It is also needed for scans (CT, MRI, PET).
Durable Medical Equipment (DME) and Supplies	Medical equipment and supplies that can be used more than once for health services. These DME and supplies are covered: • Cochlear implants (covered for ages 20 and under; batteries are covered for all ages) • Diabetic supplies • Enteral/parenteral nutrition and supplies • Incontinence supplies (for ages 3 and older) • Orthotics and prosthetics (orthotics may not be replaced for 12 months from the date of purchase. Prosthetics may not be replaced for five years from the date of purchase.) • Oxygen and supplies (Ventilator equipment is only covered when you are on a ventilator in the home) • Wheelchairs - No limits for ages 2 and older. - One wheelchair in a two year period for ages 20 and under. - One wheelchair every five years for ages 21 and older. • Wound care	Prior authorization is needed for: • All rental or leased 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 • Continuous glucose monitors • Diabetic supplies • Enteral/Parenteral nutrition and supplies • Insulin infusion device • Left Ventricular Assist Device (LVAD) • Orthotics/prosthetics • Patient transfer systems/hoyer lifts • Spinal cord stimulators • Some wheelchairs, accessories and power wheelchair repairs • Wound vacs

Service	More Information	Requirements
Emergency Services	An emergency is a medical problem that must be treated right away. Emergency services are always covered. Learn more on **page 29**.	
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. Sterilization is only covered when: a) The procedure is voluntary. b) You are at least 21 years old and not institutionalized. c) You are mentally and legally able to consent. The consent must be documented and submitted with the claim. Consent cannot be given if you are in labor, during birth, seeking an abortion or are under the influence of substances. d) The sterilization is done at least 30 days but no more than 180 days after you give consent. The exception is if delivery is premature or the was an emergency abdominal surgery. In this case, 72 hours is fine. You can get family planning services from any Arkansas Medicaid provider. They do not have to be in-network.	Prior authorization is needed for: • Artificial insemination • Infertility diagnostic services
Federally Qualified Health Center (FQHC) and Rural Health Clinic (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 like physical therapy, speech pathology, audiology, podiatry and mental health services.	
Hearing Services	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 aid repairs

Service	More Information	Requirements
Home and Community-Based Services	Home and Community-Based Services help you stay at home and in your community instead of going to a nursing home, hospital, intermediate care facility (ICF) or residential treatment facility. Your care coordinator can help you get any of the home and community-based services you need.	Prior authorization is needed for: • Adaptive equipment • Adult rehabilitative day service • Behavioral assistance • Caregiver respite services • Community transitional services • Consultation services • Crisis intervention • Emergency and planned respite • Environmental modifications • Mobile crisis intervention • Residential community Reintegration Program • Specialized medical supplies • Supportive employment • Supportive life skills development • Supplemental support services • Therapeutic communities • Therapeutic host homes Other services are also available. They do not need prior authorization until your benefit limit has been reached. Work with your care coordinator or call Member Services to learn more.

Service	More Information	Requirements
Hospice Services	Care for those who are terminally ill. Hospice services must be given mainly in your home. Hospice care can be given in a facility for those with intellectual disabilities (ICF/IID) if: a) The Department of Health and Human Services says that you are eligible. b) There is a written agreement that: - Hospice handles the professional management of the hospice care, and - The facility agrees to provide room and board.	
Inpatient Hospital Services	Procedures or tests done in a hospital or medical center. They usually need an overnight stay.	Prior authorization is needed for inpatient hospital services.
Maternity Care	Covered care includes prenatal and postpartum care, at-risk pregnancy services and gynecological care. Lamaze, parent education and breastfeeding classes are also covered. You may self-refer to any women's health specialist in our network. You can also visit your PCP.	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. Lamaze, parent education and breastfeeding classes are limited to six classes each pregnancy.
Outpatient Services (Facility and Professional)	Procedures or tests done without an overnight stay. These services are covered: • Blood services • Chemotherapy/radiation therapy • Dialysis • Imaging (CT/PET/MRI) • Infusion therapy • Observation services • Outpatient hospital diagnostic Procedures, labs and tests • Outpatient hospital surgery and Ambulatory Surgical Center (ASC) • X-Rays and diagnostic imaging	Prior authorization may be needed for some surgeries and procedures. Check with your care coordinator or call Member Services to learn more.

Service	More Information	Requirements
Out-of-Network Providers	Doctors, hospitals, pharmacies or other providers that have not signed a contract to give services to CareSource PASSE members. Your care coordinator or Member Services can help you find a provider in our network. You can also visit **findadoctor.CareSource.com** to find one near you.	Prior authorization is needed for any care you get from out-of-network providers.
Pain Management Services	These services help improve the quality of life if you live with chronic pain. These services are covered: • Epidurals • Facet joint interventions • Facets medial nerve branch • Implanted pain pumps • Intraosseous basivertebral nerve ablation • Joint fusions • Sacroiliac joint injections • Spinal Code Stimulators (SCS) • Trigger point injections	These services need prior authorization: • Facet joint interventions • Implanted pain pumps • Sacroiliac joint procedures • Sacroiliac joint fusion • Trigger point injections
Physical, Speech, and Occupational Therapy	Physical therapy treats pain and weakness through exercise and other therapies. Speech therapy teaches you express a sound or word clearly and can help with issues swallowing or chewing. Occupational therapy can help improve your cognitive, physical and motor skills. There are no limits on programs for ages 20 and under.	Prior authorization may be needed for some programs. Check with your care coordinator or call Member Services to learn more.

Service	More Information	Requirements
Physical, Speech, and Occupational Therapy	These programs are covered for ages 21 and older: • Adult developmental day treatment services • Critical access hospital • End-Stage Renal Disease (ESRD) • Home health • Hospice • Independent lab/ Certified Registered Nurse Anesthetist (CRNA)/radiation therapy centers	
Physical Exams	A checkup with a provider to go over your medical history and check your health and fitness.	A physical exam that is needed for a job or to take part in job training is covered if the exam is not free through another source.
Podiatry Services	Services for your feet.	There are no limits for medical visits in a non-hospital setting for age 20 and under. Prior authorization is needed for age 21 and up.
Prescription Drugs, including prescribed Over-the-Counter Drugs	All medically necessary Medicaid-covered medications are covered. We use a Preferred Drug List (PDL).	Prior authorization varies by drug. Check with your care coordinator or call Member Services to learn more.
Prostate Cancer Screening	Screenings for prostate cancer for men are covered.	
Primary Care Provider (PCP)	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.	
Residential Treatment	Places where you get therapy for substance use disorder, mental illness, or other behavioral problems.	Prior authorization is needed for residential treatment.
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. Your provider can give you the care if it is medically necessary.	

Service	More Information	Requirements
Shots (Immunizations)	Immunizations help 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 to get your shots at the right time.	
Specialists	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. Your care coordinator or Member Services can help you find a specialist. You can also visit **findadoctor.CareSource.com** to find one near you.	Your PCP will give you a referral to see most specialists. Specialists outside of our network need prior authorization.
Telehealth	Visit with a provider by phone or computer from wherever you are. Your PCP may offer telehealth. Contact their office to find out.	
Urgent Care	Urgent care is for non-emergencies when you cannot see your provider right away. They help keep an injury, sickness or mental health issue from getting worse.	Check with the urgent care you want to go to about any requirements they have for Medicaid or PASSE members before you go.
Vision Services	Eye exams, routine checkups and services you get from an eye doctor: • One exam each year is covered. • One pair of glasses (or lenses if keeping the same frames) is covered each year for all ages.	Surgical evaluation is needed if you have a diagnosis of ptosis, congenital cataracts, exotropia or vertical tropia between the ages 12 and 21. Tinted, photogray, and sunglasses are for post-operative cataract or albino members only.
Well-child (EPSDT) Visits	EPSDT stands for Early and Periodic Screening, Diagnostic and Treatment. It covers exams, immunizations (shots), health education and lab tests. EPSDT also covers medical, vision, hearing, nutritional, developmental and behavioral health exams. See **page 24** to learn more about these visits.	EPSDT visits are for those under the age of 21.

BENEFITS

Mental Health Care

Good health is more than just taking care of physical needs. Your mental health is a key part of your overall health. Whether you deal with depression, anxiety, alcohol or drug dependence, there is support. Call Member Services or work with your care coordinator to find the right mental health provider. You can also go to **findadoctor.CareSource.com** to find one near you. Call or text 988 if you have a mental health crisis or emergency.

Vision Care

Caring for your eyes can lead to a better quality of life. Your eyesight impacts how well you do at work, school, and home. Routine eye exams from an eye doctor and glasses are covered.

Versant

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

Extra Benefits

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.

KidsHealth

KidsHealth® is a trusted resource for the whole family. KidsHealth has articles, videos, interactive health tools and doctor tips on hundreds of health topics. Learn more at **kidshealth.org**.

MyResources

Sometimes you just need a little extra help. We have a search tool called MyResources that helps you find programs for food, shelter, school, work, financial support, and more! You can use this tool through your My CareSource account or by going to **CareSource.findhelp.com**. You can also call Member Services to find support near you.

PREVENTIVE CARE

Preventive care is key for the whole family. Seeing your provider on a routine basis even if you are healthy helps them find and treat problems early before they get worse.

Check out the chart of preventive care to get based on your age. The chart is only a guide. Your provider will know what is 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 (get tested if you are younger than 20 and sexually active)	✓				
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	✓	✓	✓	✓	✓

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

EPSDT covers care for those under the age of 21 at no cost to you. EPSDT stands for:

Early - So problems are treated soon.

Periodic - To set up routine visits.

Screening - To check for a health problem.

Diagnostic - To find a health problem.

Treatment - To care for a problem.

EPSDT includes:

- ✓ Well-child exams
- ✓ Vision and hearing tests
- ✓ Health education
- ✓ Lab testing
- ✓ Lead screening

EPSDT also covers medically necessary care for issues found by an exam. This includes things like glasses and hearing aids.

When should children have an EPSDT check?

From birth to 15 months of age, children may have six checks after the newborn exam. Children age 15 months to 24 months may have two checks. Children may have one check between the ages of 24 months to 30 months and again between 30 months to three years old.

PREGNANCY AND FAMILY PLANNING

We want you to have a healthy pregnancy. Family planning helps:

- ✓ You be healthy before getting pregnant.
- ✓ Put off pregnancy until you are ready.
- ✓ Protect you and your partner from sexually transmitted infections.

Before You Are Pregnant

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

- 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 spot problems before they happen.

After You Have Your Baby

Call Member Services 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 1 in 8 people suffer from **postpartum depression (PPD)** after they give birth. Signs of PPD are feelings of hopelessness or helplessness, severe mood swings, withdrawing from family and friends, fear that you are not a good parent, or thoughts of harming yourself or your baby. PPD can last for many months or longer if it is not treated.

Your mental health matters. Call your provider right away if you notice any signs or symptoms of PPD. Call 911 or 988 if it is an emergency. You need to take care of yourself just like you take care of your baby.

Plan To Breastfeed?

We want you to have the tools you need if you plan to breastfeed. You can get breast pumps and other supplies through the Arkansas Health Department. Your care coordinator will work with you to get what you need.

WHERE TO GET CARE

Primary Care Provider (PCP)

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

Telehealth

Visit with a provider by phone or computer from wherever you are. Ask your providers if they offer telehealth.

Urgent Care

Used to treat non-life threatening issues. When your provider is not available and your health issue cannot wait.

Emergency Room

Used for life-threatening issues. Call 911 or go to the nearest ER.

Not sure where to go for care? Call CareSource24 at **1-833-687-7305** (TDD/TTY: 711). We are here for you 24 hours a day, 7 days a week.

Primary Care Provider (PCP)

Your PCP will play a big role in your preventive care. Seeing them on a routine basis helps them get to know you and your needs so they can give the best care. PCPs can be:

- General or family doctors
- Pediatricians
- Internists
- OB/GYNs
- Physician Assistants
- Nurse Practitioners
- Psychiatrists for those with major mental health issues
- Specialists for those with chronic conditions
- Public health department clinics and hospital outpatient clinics
- Federally Qualified Health Centers or Rural Health Clinics

Some examples of what 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
- Joint pains
- Earache
- Constipation
- Rash
- Sore throat
- Loss of appetite
- Restlessness
- Pain management
- Colds/flu
- Headache
- Removal of stitches
- Vaginal discharge
- Pregnancy tests
- Backache

If your PCP is not able to treat your health issue, they will send you to other providers or a specialist. Your PCP can also admit you to the hospital.

Changing Your PCP

If your PCP moves, retires, or leaves our network, we will let you know in writing within 30 days. We will tell you if any local hospitals or providers you see are no longer in our network.

Your care coordinator or Member Services can help you find a provider in our network. You can also visit **findadoctor.CareSource.com** to find one near you.

Appointments

Please plan visits with your providers as far in the future as you can. Always go to your planned visits. Call the provider's office at least 24 hours before if you need to change or cancel a visit.

Second Opinion

You have the right to ask for a second opinion about a diagnosis, surgery, or other treatment. You can get it from a provider out of our network if you do not find an in-network provider.

Telehealth

Telehealth uses your phone, computer or tablet to speak to a provider. You can visit with a provider from wherever you are. It removes the stress of needing a ride to and from the provider's office.

You can use telehealth for many common issues like sinus infections, allergies, rashes and more. It can give you quick medical advice to keep your issue from getting worse. Your providers may offer telehealth. Check with them to find out.

Urgent Care

Urgent care is for non-emergencies. You should go to one if you cannot visit your provider quickly enough. They help keep an injury, sickness or mental health issue from getting worse. Always check in with your care coordinator after your visit.

Emergency Services

Emergency services are for severe health issues that must be treated right away. Examples are:

- Miscarriage/pregnancy with vaginal bleeding
- Severe chest pain
- Shortness of breath
- Loss of consciousness
- Seizures/convulsions
- Severe vomiting
- Rape
- Major Burns
- Sudden change in your mental health
- Suicidal thoughts
- Uncontrolled bleeding

If you need emergency care:

- Go to the nearest ER or call 911. There is no need to call us. Your health comes first.
- Show your member ID card. Tell the staff you are covered by CareSource PASSE.
- If they treat your emergency but think you need more care or need to stay in the hospital, they must call us within 24 hours.

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 when you are traveling. Here are suggestions for what to do if this happens:

- **If it is an emergency:** Call 911 or go to the nearest ER.
- **If it is not an emergency:** Call your provider for help about what to do.
- **If you're not sure if it is an emergency:** Call CareSource24 at **1-833-687-7305** (TDD/TTY: 711). We can help you decide what to do.

Follow Up Care

You may need more care after your emergency. This is called follow up care. Check in with your care coordinator after your visit. They will help you with any follow-up care you need.

PHARMACY

Prescription Drugs

We pay for all medically necessary, CMS participating, FDA-approved products on the Preferred Drug List (PDL). These are drugs we prefer your provider prescribe. You can get the PDL at **CareSourcePASSE.com**.

When you need to get or refill a prescription, find a pharmacy close to you that takes CareSource PASSE. Use our Find a Pharmacy tool at **CareSourcePASSE.com**. Be sure to bring your member ID card.

Prior Authorization

We may ask your provider why you need a certain type or dose of medicine. Prior authorization may be needed if:

- There is a generic or drugstore alternative drug.
- The drug can be misused or abused.
- There are other drugs that should be tried first.

Some drugs have limits. Some drugs are never covered. If we do not approve a drug, we will tell you how to ask for an appeal and your right to a state fair hearing.

Step Therapy

You may need to try one or more drugs on the PDL before taking one that is not on the PDL. This is called Step Therapy. Some drugs are only covered if Step Therapy is used.

Generic Substitution

A pharmacy may give you a generic drug in place of a brand-name drug. This is called a generic substitution. Generic drugs have the same effect and safety as brand-name drugs. Your provider will need approval from us if they ask for a brand-name drug when there is a generic drug available. This is unless the brand is noted as preferred.

Therapeutic Interchange

Sometimes you cannot take a certain drug, like if you have an allergy. Other times, a drug might not work for you. In these cases, your provider can ask us to cover a drug that is not on the PDL.

Exceptions

You may ask us to cover a drug not on the PDL. This is called an exception. You may ask for an exception because of an allergy, not being able to take a drug, or a poor response to the PDL drug. We will work with your provider to get what we need after we get your request.

Specialty Medications

Some drugs have special rules, complicated administration, or need to be monitored. They may need to be given to you by your provider. These are called specialty drugs. Most of these drugs need prior authorization. If it is approved, we will work with your provider and the pharmacy to get what you need.

Ask Your CareSource PASSE Pharmacist

Do you have questions about your medications? Talk to a CareSource PASSE pharmacist! They can look over your medications with you and answer questions. You do not need an appointment! Call **1-833-230-2073** to speak with a pharmacist today. We are open Monday through Friday, 8 a.m. to 4:30 p.m. CT.

Lock-In Program

The lock-in program protects members who use controlled substances more than what is medically necessary. Lock-in members get their medicines filled at one pharmacy and use their primary care provider for medical care.

Medication Therapy Management (MTM) Program

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

- Help you safely use your drugs.
- 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.

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

CAREGIVER RESOURCES

If you are a caregiver for a spouse, parent, child or loved one, you know it is hard. It takes a lot of time, effort, and work. We want to make it easier. Your loved one's care coordinator is a great resource to you. They can help find support like in-home care, meals on wheels, home repair programs and more.

Helpful Resources for Caregivers

We do not endorse any of these groups or their resources. They are here for reference only.

Aging Care

Education for those who care for aging adults. They also have an active online community for caregivers.

www.agingcare.com

Arkansas Association of Area Agencies on Aging (5A)

Has information and resources for aging adults and their caregivers on elder care.

www.agingarkansas.org

Arkansas Disability Coalition

Helps families and those with all types of disabilities with support, information, resources, and training.

www.ardisabilitycoalition.org
(501) 614-7020

Arkansas State Independent Living Council

Promotes independent living for people with disabilities.

www.arsilc.org
(501) 372-0607

Caregiver Action Network

Has education, resource, and support for those who care for loved ones with chronic conditions, disabilities, disease or old age.

www.caregiveraction.org
(855) 227-3640

Disability Rights Arkansas

Advocates for the civil and legal rights of people with disabilities.

www.disabilityrightsar.org
(501) 296-1775

Family Caregiver Alliance

Supports caregivers through research, advocacy and services.

www.caregiver.org
(800) 445-8106

Family Voices

Has information on health care policies related to children with special needs.

www.familyvoices.org
(888) 835-5669

Grandfamilies

Has information on laws and policies for grandparents raising grandchildren.

www.grandfamilies.org

NAMI Arkansas

Helps people living with mental illness, their families and the community.

www.namiarkansas.org/home
(800) 844-0381

National Federation of Families

Advocate for families who have children with emotional, behavioral, mental health and substance use issues.

www.ffcmh.org
(240) 403-1901

National Institute of Mental Health

Information on mental disorders and the latest mental health research.

www.nimh.nih.gov

Substance Abuse and Mental Health Services

Information through the U.S. Department of Health and Human Services.

www.samhsa.gov

Sources of Arkansas

Has services, support and advocacy for those with disabilities and their families.

www.arsources.org
(888) 284-7521

ABUSE, NEGLECT, OR EXPLOITATION

People who rely on someone else to care for them can be mistreated. Abusers can be anyone. They can be family, friends, providers, neighbors, teachers or caregivers. Those with power or control over someone can take advantage of that person. Know what abuse, neglect or exploitation is so that you can see the signs and take action.

Words to Know

Consent – to allow or agree to.

Abuse can happen in many ways.

- **Physical abuse** is when someone hurts you on purpose. This can be hitting, slapping or anything that causes pain or harm.
- **Emotional abuse** is when someone uses threats, pressure, or insults to control you. They may try to keep an eye on your calls and emails. They may also keep you from family or friends.
- **Financial abuse** is when someone takes control of your money without your approval. They could also use credit cards and checks.
- **Sexual abuse** is any kind of sexual contact without your approval. This could be rape, touching, groping or any other sexual activity where there was no consent. It is sexual abuse if you are under the age of 18 or are not able to fully consent.

Neglect is when someone keeps basic needs from you. This could be things like food, clothing, shelter or medical care.

Exploitation is when someone takes or misuses your belongings or your identity. This can include your money.

Signs are:

- Changes in behavior (not wanting to go places or see people).
- Mood changes (more withdrawn, scared, sad, or anxious).
- Unexplained injuries like cuts, bruises, burns or broken bones.
- Overmedication.
- Lack of medical care or treatment.
- Being left alone for long periods of time.
- Poor hygiene (body odor, dirty hair, skin, clothing).
- Unsanitary or unsafe living conditions.
- Pressure or bed sores.
- Unpaid bills.
- Taking out large amounts of money from the bank.
- Forged checks.

Talk to your provider or care coordinator if you feel like you may be a victim. They can help. You can also call our CareSource24 Nurse Advice Line.

Here are some tips for you to help someone else:

- Listen and tell them that it is not their fault. There is nothing to feel bad or be embarrassed about.
- Refer them to groups who support victims.
- Report it to the school, social services, health care workers, or the state or local child or adult protective services.

Helpful Groups

Children's Advocacy Centers of Arkansas

www.cacarkansas.org
1-800-482-5964

The National Domestic Violence Hotline

www.ndvh.org
1-800-799-7233 (SAFE)

Disability Rights Arkansas

www.disabilityrightsar.org
1-800-482-1174

Partners Against Trafficking Humans (PATH)

www.pathsaves.org
1-501-301-4357

Love is Respect

www.loveisrespect.org
1-866-331-9474

RAINN

www.rainn.org
1-800-656-4673 (HOPE)

National Center on Elder Abuse

www.aginginplace.org
1-855-500-3537

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

You have a right to:

- Get information about us, our services, our providers, and your rights and responsibilities.
- Understand CareSource PASSE and your Person-Centered Service Plan (PCSP) and get services through it.
- Have information on PASSE services that we offer. This includes:
  - Covered benefits and how to get them.
  - If prior authorization is needed for any benefits.
- Take part in decisions about your care. This also mean the right to say no to treatment.
- Learn more about treatments and alternatives in a way that you can understand.
- Know and talk through needed treatments for your health issue(s). It does not matter what the cost or coverage is.
- Make an advance directive without fear of being treated unfairly.
  - File a complaint if you feel your advance directive is not followed with the Arkansas Department of Human Services (DHS) at 501-682-8292 (TTY/TDD: 711).
- Make suggestions about our member rights and responsibilities.
- Be treated with respect and with regard for your dignity and privacy.
- Have your personal information and health records kept private.
- Be free from any form of restraint or seclusion used to coerce, discipline, convenience, or retaliate against you.
- Live in an integrated and supported setting in the community.
- Have control over certain aspects of your life.
- Be protected in the community.
- Be treated in a way that respects your culture and health care customs.
- Get all written member materials:
  - At no cost to you.
  - In your primary language.
  - In other formats like large print, braille or audio.
- Choose your own in-network provider for care you can get under your PCSP.

- Women have the right to see a women's health provider for covered women's health care.
- Ask for and get a copy of your medical records. You can also ask for them to be changed or fixed.
- Carry out your rights and know that we, our providers, or DHS will not hold this against you.
- File a grievance or appeal and ask for a state fair hearing.
- Voice complaints or file a complaint against us or our providers.
- Know that we must follow all federal and state laws, and other laws about privacy.
- Get all health care services covered under CareSource PASSE and Medicaid timely.
- Get a covered service outside of our network if we cannot give it to you in-network. If you are approved to go out-of-network, it will not cost more than if you got them in-network.
- Get a letter within seven business days if there is a change in your care coordinator.
- Get a member handbook and provider directory sent or made available to you within five business days of joining CareSource PASSE.
- Get a second opinion for a treatment. If a network provider is not available, you can get a one from outside of our network.
- Get information from Member Services about:
  - Our structure, governance, and operation.
  - How we rate on metrics and measures tracked by DHS or Center for Medicaid Services.
  - Our non-discrimination policies and who enforces them. Who answers to accessibility and discrimination claims made against us.
  - A list of services not provided by CareSource PASSE due to moral or religious objections. How you can learn more about and get those services through DHS.
- Not be discriminated against due to race, color, religion, gender, gender identity, sexual orientation, age, national origin, veteran status, ancestry, medical condition (including physical and mental illness), claims experience, receipt of health care, medical history, genetic information or evidence of insurability or disability. Reach out to the U.S. Department of Health and Human Services if you feel you have been discriminated against:

Address: 	200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C. 20201
Email: 	OCRComplaint@hhs.gov
Online: 	https://www.hhs.gov/civil-rights/filing-a-complaint/index.html

Your Responsibilities

- Use providers in our network.
- Go to all your planned visits to your providers. Be on time and call 24 hours before the visit if you need to cancel.
- Follow the instructions for care from your providers.
- Know the rules to follow to get covered services and care.
- Always have your ID card with you. Show it when getting care.
- Never let others use your ID card.
- Let us, DHS and your providers know if you change in your phone number or address.
- Let us, DHS and your providers know if you are covered by other health insurance.
- Let your care coordinator know after you go to urgent care or after getting medical or behavioral health care. They can help you with any follow up care you may need.
- Give the information that CareSource PASSE and your providers need, to the extent possible, to provide care.
- Tell us of if you suspect fraud, waste, abuse, or overpayment.
- Know as much as you can about your health issues and take part in reaching goals agreed to with your providers.
- Report child or adult abuse or neglect to us or:

Arkansas Suspected Child Abuse	
Phone:	1-800-482-5964
Online:	https://static.ark.org/eeuploads/asp/cacd_suspected_abuse_fax_template_112013.pdf

Arkansas Adult Protective Services	
Phone:	1-800-482-8049
Online:	https://arkansas.leapsportal.net/LEAPSINTAKE/PublicIntake_501.aspx

MEMBERSHIP AND ELIGIBILITY

You need to be eligible for Medicaid to be part of any PASSE. The State of Arkansas decides who is eligible. Not CareSource PASSE.

Enrollment

There is an open enrollment period each year. This is when you can change your PASSE. The State of Arkansas will send you a letter that will tell you what you can do to change your PASSE.

Changing Your PASSE

If you would like to change your PASSE, you can do that within the first 90 days of being assigned to a PASSE. After 90 days, you can only change during the next 12 months for cause.

Here are reasons you can change:

- You move out of state.
- You do not have access to covered services.
- There are no providers who know how to deal with your health care needs.
- You get poor quality care.
- DHS sanctions CareSource PASSE.
- Other reasons determined by DHS.

To change PASSEs, call PASSE Beneficiary Support at 1-833-402-0672. They will decide if you can change. We are not part of this decision.

If it is approved, the start date with your new PASSE will be no later than the first day of the second month after the month DHS gets your request. If DHS gets your request on March 15, the start date with your new PASSE will be no later than May 1. Your request will be approved automatically if it is not processed timely.

Disenrollment/Reinstatement

If you are disenrolled from CareSource PASSE, you may be reinstated for the next month without losing coverage. You must first restore your eligibility. Call the Medicaid Hotline at 1-800-482-8988. The State of Arkansas decides who is eligible. Not CareSource PASSE.

A lapse in eligibility that is not resolved in the above timeframe means you cannot be reinstated the next month. You will be disenrolled from CareSource PASSE. If a continuity of care issue happens and all parties agree to it, then you can be reinstated. Call Access Arkansas at 1-855-372-1084 if you have any questions.

Major Life Changes

Life changes can happen at any time. Life changes can affect your Medicaid eligibility. Call the Medicaid Hotline at 1-800-482-8988 within 10 days of the major change.

Major life changes are:

- Name change.
- Moving to a new address, new county or out of state.
- Pregnancy or a change in family size.
- Job changes or a change in your pay.
- Disability change.

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 so. Many people make them while they 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 can file a complaint with the Arkansas Department of Human Services at 501-682-8292 (TTY/TDD: 711) if you feel like your advance directive is not followed.

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. A copy should be given to your family, health care agent, and providers. Please call Member Services if you would like to learn more.

Standard Forms of Declarations

Arkansas law has two standard forms of declarations. One deals with what would happen if you had a terminal illness. The other deals with what would happen if you were permanently unconscious. You may use either or both forms. You can get these forms or find out where to get them from your provider or from a lawyer.

The standard forms do not always cover all the choices you can make. You may wish to have more instructions about your care. Please talk to a lawyer to add more details to your standard form.

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 think about all fair requests. We must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share.

You can ask us not to use or share certain health information for care, payment or our operations. We do not have to agree to these requests.

Get a list of who we have shared information with.

You can ask how many times we have shared your health information. This can only be up to six years before the date you asked. You can ask who we shared it with and why. We will have all of 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 PASSE 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.

You can file a complaint.

You can complain if you feel we have violated your rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

Phone: 1-877-696-6775

Online: https://www.hhs.gov/ocr/complaints/index.html

Address: Department of Health and Human Services Office for Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201

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

Your Choices

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

- With your family, close friends or others who pay for your care.
- In a disaster relief situation.

If you cannot tell us your choice, such as if you are unconscious, we may share your information. We may share it if we believe it is in your best interest. We may also share if we need to reduce a serious and close threat to health or safety.

We cannot share your information unless you have given us written consent for:

- Marketing uses.
- 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 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 must meet many rules in the law before we can share your information. Go to **https://www.hhs.gov/hipaa/index.html** to learn more.

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 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 requests if you die. We can share with organ donation groups. We can also share with a coroner, medical examiner or funeral director.

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 based on a court or legal order. We may also make a group of "de-identified" information that cannot be traced back you.

Our Responsibilities

- We protect your health information in many ways. This is information that is written, spoken, or found online.
  - 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.

To learn more, visit **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Effective date and changes to the terms of this notice

This privacy notice is effective April 28, 2017. 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.

Phone: **1-833-230-2005** (TDD/TTY: 711)

Email: **HIPAAPrivacyOfficer@CareSource.com**

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

This information is for general use only. It is not meant to be legal advice.

UTILIZATION MANAGEMENT

Our Utilization Management (UM) team reviews the health care you get based on a set of guidelines. We 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. We are open for calls Monday through Friday from 8 a.m. to 5 p.m. Central Time. You can leave a message about UM issues after these hours. Reach UM using the *Tell Us* form at **CareSourcePASSE.com**.

Authorization Time Frames

We will decide standard requests within two business days after getting the information we need. We will tell you and your provider if it has been approved. You, your provider or CareSource PASSE can ask for more time to review. The review can last up to two weeks.

Your provider or CareSource PASSE can ask for an urgent authorization. This would prevent:

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

We will decide these requests within one business day. We can ask for up to five business 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 use research and advances in science to make sure that you get quality care. This review is aligned with our benefits so we have the most up-to-date, effective and affordable care.

Service Determination

Our Service Determination team uses your PCSP as the main driver of care. We also use clinical guidelines and best practices. Knowing what you want out of your life helps drive what services and supports are needed to meet those goals.

FRAUD, WASTE, ABUSE, AND OVERPAYMENT

Our Program Integrity team handles cases of fraud, waste, abuse or overpayment. 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 PASSE.

Overpayment – when CareSource PASSE pays for care that is not needed.

If You Suspect Fraud, Waste, Abuse or Overpayment:

Call: 1-833-230-2005 (TDD/TTY: 711). Select the menu choice to report fraud.

Fill out the Fraud, Waste and Abuse Reporting Form. It is at **CareSourcePASSE.com** under *Forms*. We can also mail you a printed copy.

Write a letter to: CareSource PASSE
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

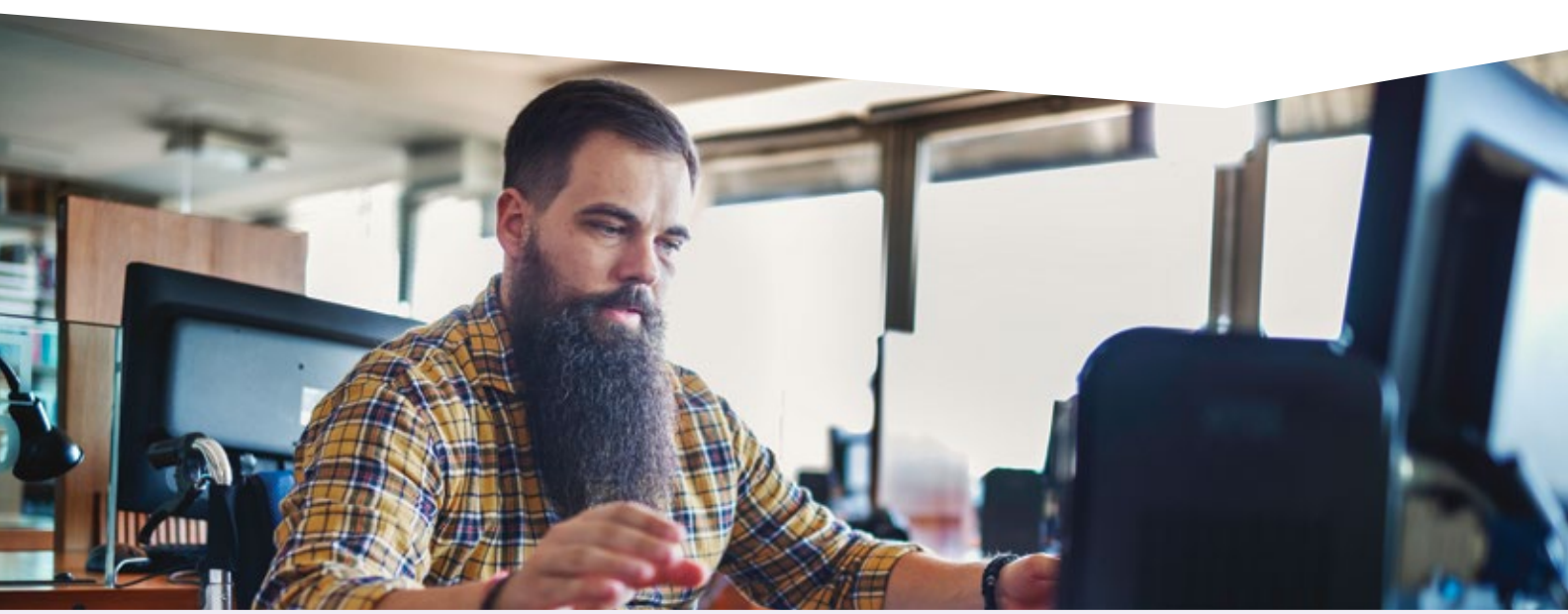
You do not have to give us your name when you write or call. If you are not worried about giving your name, you may also send an email* or fax. Please give us as many facts as you can. Add names and phone numbers. If we do not get your name, we will not be able to call you back for more information.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

Email: fraud@CareSource.com

Fax: 1-800-418-0248

*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.

Thanks for helping us keep fraud, waste, abuse and overpayment out of health care.



GRIEVANCES AND APPEALS

Let us know if you are unhappy or do not agree with a decision made by us or our providers. Please call Member Services if you need help filing a grievance or an appeal.

Words to Know

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

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

Grievances

A grievance is a formal complaint about us, our providers or the care you get. You or an authorized representative may file a grievance at any time.

Call Member Services at **1-833-230-2005** (TDD/TTY: 711). We can also mail you a paper form.

Fill out the grievance and appeals form. It is at **CareSourcePASSE.com** under *Forms*. We can also mail you a printed copy.

Mail a letter to:
CareSource PASSE
Attn: Member Grievances
P.O. Box 1947
Dayton, OH 45401-1947

Grievance Process

We will send you a letter within five business days to let you know that we got your grievance. We will reply within 30 days. The people who decide grievances are health care professionals. They report to the CareSource PASSE medical director. They are not part of prior reviews or decisions.

Please call Member Services if you are not happy with our decision. You can also file a complaint at any time to the Arkansas Department of Human Services.

Mail a letter to: Arkansas Department of Human Services Division of Medical Services
P.O. Box 1437 Slot S-418
Little Rock, AR 72203-1437

Call: 501-682-8292 (TTY/TDD: 711)

Fax: 501-682-1197

Appeals

An appeal is how you ask us to review our actions. You might get a decision letter telling you that a service is ending. You can appeal if you disagree. You must ask for one within 60 days from the date listed on the letter. You or an authorized representative can file.

Call Member Services at **1-833-230-2005** (TDD/TTY: 711). We can also mail you a paper form.

Fill out the grievance and appeals form. It is at **CareSourcePASSE.com** under *Forms*. We can also mail you a printed copy.

Mail a letter to:
CareSource PASSE Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401-1947

Words to Know

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

Expedite – To hurry, speed up or make something go faster.

Who can ask for an appeal?

- You
- Your provider with your written consent
- Someone that you say can act on your behalf
- Your parent of legal guardian
- An attorney with your written consent

When can you ask for an appeal?

You can ask for an appeal within 60 calendar days of the date listed on the decision letter. We will let you know in writing within 5 business days that we got it. We will give you an answer within 30 calendar days once we get your appeal. You can file an appeal by phone or in writing.

How can you expedite your appeal?

You can ask for an expedited (fast) appeal in writing or by phone. If you or your provider think that waiting up to 30 calendar days could seriously risk your life or health, please tell us. Serious risk to your life or health means you are able to reach, keep, or get back to your maximum function.

If we agree that you need an expedited appeal, we will decide within 72 hours. If we do not agree, we will call you no later than the close of business that day. We will also send you a letter with the reason for the delay within two calendar days. We will then decide within 30 calendar days.

You must file an expedited appeal within 60 calendar days from the date listed on the decision letter. A qualified reviewer who was not part of the first decision will look it over. We may extend the review by up to 14 calendar days. We can do this if you ask for it. We can also extend it if we need more information, and it is in your best interest.

What must your appeal have?

- ✓ Your name
- ✓ Your member ID number
- ✓ The provider's name
- ✓ The date of the service
- ✓ The reason for your appeal
- ✓ Information you want to attach
- ✓ A phone number where we can reach you

Who can help you file your appeal?

Your care coordinator or Member Services can help you file.

How do you keep getting the services during an appeal?

If you are getting approved services that are now denied, you have the right to keep getting them during the appeal process. Your appeal must clearly state you wish to keep getting the services. You must let us know that within 10 calendar days from the date listed on your decision letter. If you keep getting the service, you may have to pay if:

- You withdraw the appeal.
- The decision is not in your favor.
- The time period or service limits of the approved service has expired.

State Fair Hearings

You or your authorized representative can ask for a State Fair Hearing if you do not agree with the appeal decision. You can also ask if is not resolved within 30 calendar days for a standard request or 72 hours for an expedited request. You must ask for a hearing **within 90 calendar days** of the date on your decision letter.

How do you ask for a State Fair Hearing?

Send a letter to: DHS Office of Appeals & Hearings
P.O. Box 1437, Slot S101
Little Rock, AR 72203-1437

Call: 501-682-8622 (TTY/TDD: 711)

Fax: 501-404-4628

Email: DHS.appeals@dhs.arkansas.gov

Who can ask for a State Fair Hearing?

You or your authorized representative may ask for a State Fair Hearing. After you ask for this:

- We will give the Adverse Benefits Determination and Notice of Appeal resolution letters within 2 business days to the DHS Office of Appeals and Hearings.
- We will send an evidence packet to you and the State Fair Hearing officer within 10 business days.

Who can represent you at a State Fair Hearing?

You have the right to be represented by a lawyer if you choose.

How do you keep getting services during a State Fair Hearing?

If you get approved services that are now denied, you have the right to get them during the State Fair Hearing process. You must ask to keep getting the services within 10 calendar days from the date listed on your decision letter. If you keep getting the service, you may have to pay if:

- You withdraw the hearing request.
- You withdraw the request for continuation of services.
- The decision is not in your favor.

What happens at a State Fair Hearing?

We will go over why we made our decision. You will then go over why you think we were wrong. The hearing officer will listen and decide who is right. Their decision will be based on the information given and whether we followed the rules.

- If it is in your favor, we will provide the services as quickly as we can. It will be no more than 72 hours after the decision.
- If it is not in your favor, we may ask you to pay for the services you got while the appeal and/or State Fair Hearing were going on.

WORD MEANINGS

Abuse – An action that causes unneeded costs.

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

Adverse benefits determination – Means any of these:

- Denying or limiting a service. This is based on the type, level, medical necessity, appropriateness, setting or success of a covered benefit.
- Reducing, delaying or stopping a previously approved service.
- Denying all or part of a payment for a service.
- Not giving care in a timely way.
- CareSource PASSE not acting in the right time frames.
- Denying your right to argue a charge.

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

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

Arkansas Independent Assessment (ARIA) – An assessment that determines if you can be part of the PASSE program. It is done by a person who does not work for DHS, a PASSE or 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 PASSE.

Business days – Monday through Friday, 8 a.m. to 5 p.m. Central Time, except for holidays.

Calendar days – Each day, along with weekends and holidays.

Care coordination – All parts of your care, services, and supports that are managed on an ongoing and uninterrupted basis.

Care coordinator – Your main point of contact for your care. They help you keep track of all your providers and health services.

Chronic health 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.

Community mental health centers – Offices that give you mental health care.

Community Support Systems Providers (CSSP) – Care for your behavioral health and/or intellectual/developmental disabilities.

Condition – An illness, disease or health problem.

Consent – to allow or agree to.

Copayment/Copay – Part of the cost for care you must pay.

Covered services – Medically necessary health care that we pay for.

DHS – Arkansas Department of Human Services.

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

Disenrollment – Removing a member from CareSource PASSE.

Durable Medical Equipment (DME) – Supplies that can be used more than once for health services.

Electroconvulsive Therapy (ECT) – a form of brain stimulation. ECT sends electrical waves to the brain. It can help treat symptoms in people with depression or bipolar disorder when other treatments have failed. ECT may start during a hospital stay. It can happen in the hospital or in an outpatient setting.

Emancipated minor – A person under the age of 18 who is legally free from parent control.

Emergency care – Care you get for life-threatening issues that must be treated right away.

Emergency medical condition – An illness, injury, symptom or condition that needs care right away. If you do not get this care:

- Your health would be in danger; or
- You would have problems with your bodily functions; or
- You would have damage to any part or organ of your body.

EPSDT – **E**arly and **P**eriodic **S**creening, **D**iagnostic and **T**reatment. This is preventive care given to those under the age of 21.

Excluded services – Care that we do not pay for or cover.

Expedited review – A process to help you get the care you request more quickly.

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

Fraud – Misusing benefits on purpose.

Grievance – A complaint about us or our providers.

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. This may involve physical and occupational therapy, speech-language pathology and other services for people with disabilities.

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

Health insurance – A contract that makes sure your health insurer pays your covered health care costs.

Home and Community-Based Services (HCBS) – Helps you stay at home and in your community instead of going to a nursing home, hospital or other care setting.

Home health care – All of the medical and health services that are given in your home by a provider.

Hospice – Services that give comfort and support for a person in the last stages of a terminal illness.

Hospitalization – Care in a hospital. It often includes an overnight stay.

Inpatient care – Care that you get when you are checked into a hospital. It is when you spend at least one night in a hospital setting to get care.

Medicaid – The federal health insurance program 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.

Member – A person who is part of CareSource PASSE.

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

Nonmedical Community Supports and Services (NCSS) – Services that stop or delay needing to go into or help you get ready to leave an institutional setting. They help you live safely in your own home or in the community. This could be getting help bathing, getting dressed, grocery shopping or help getting around.

Notice of Action (NOA) – A letter you get you when we make a decision about your care. It has:

- The action that is planned.
- The reason for the planned action.
- The rule or statute that supports the action.

The letter will go over your right to appeal the decision. It tells you how to ask for a State Fair Hearing. It also tells you how to ask to keep getting services during an appeal or State Fair Hearing.

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

Optometrists – Providers who care for your eyes and vision.

Out-of-network provider – A doctor, hospital, pharmacy, or other provider that has not signed a contract to give care to CareSource PASSE 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.

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

Over-the-Counter (OTC) drugs – Drugs you can often buy without a prescription.

Person-Centered Team (PCT) – Your team may include your family or caregivers, friends, your specialists, and your primary care, behavioral health, waiver and home health providers.

Person-Centered Service Plan (PCSP) – Your overall plan of care. It can help you live safely in your home and community. It will list the services you get and what you need.

Pharmacists – Providers who help with prescriptions and other medications.

Pharmacy – Where to go to get medications or prescriptions.

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

Physician services – Health care that a doctor gives or arranges.

Preferred Drug List (PDL) – A list of drugs that we cover. This is also known as a formulary.

Prescription – A provider's order for your medication.

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

Primary Care Provider (PCP) – Who you choose to be your personal doctor. They will treat you for most of your health care needs.

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 directory – A list of providers in the CareSource PASSE network. The ***Find a Doctor*** tool has the most up-to-date list of providers near you. Visit **findadoctor.CareSource.com**.

Provider-led Arkansas Shared Savings Entity (PASSE) – A plan that cares for the health needs of Medicaid members who have behavioral health disorders or intellectual developmental disabilities.

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.

Psychiatric Diagnostic Evaluation – When a mental health provider looks at you and your family's health history and social needs. They may give a diagnosis based on what you share and help you get the treatment you need. They may also connect you to other helpful services.

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.

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

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

Service determination – A team who has worked with those with intellectual and developmental disabilities. They focus on all behavioral health requests for Utilization Management.

Skilled nursing care – Care from licensed nurses in your own home or in a nursing home.

Specialist – A doctor who focuses on a certain kind of medicine or has special training in a certain type 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.

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

Waste – Using more benefits than what is needed.

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