Chapter 4: Benefits Chart

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A. Understanding your covered services

This chapter tells you what services CareSource MyCare Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, *Getting your outpatient prescription drugs through the plan*, and information about what you pay for drugs is in Chapter 6, *What you pay for your Medicare and Medicaid prescription drugs*.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. See Chapter 3, *Using the plan's coverage for your health care and other covered services*, for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at **1-855-475-3163** (TTY: 1-800-750-0750 or 711), Monday – Friday, 8 a.m. – 8 p.m., or your care manager at **1-866-206-7861**, 24 hours a day, 7 days a week.

B. Our plan does not allow providers to charge you for services

Except as indicated above, we do not allow CareSource MyCare Ohio providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a covered service.

➔ **You should never get a bill from a provider for a covered service. If you do, see Chapter 7, *Asking us to pay a bill you have gotten for covered services or drugs*.**

C. About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your care manager.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.
  - ➔ If CareSource MyCare Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, see Chapter 9.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, *Getting care from primary care providers, specialists, other network providers, and out-of-network providers,* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to receive the service. If you are not sure whether a service requires prior authorization, contact Member Services or visit our website at **CareSource.com/MyCare**.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

D. The Benefits Chart

Preventative Visits

Services covered by our plan	Limitations and exceptions
Annual checkup This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered once every 12 months. **Note:** You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	
"Welcome to Medicare" visit If you have been in Medicare Part B for 12 months or less, you can get a one-time "Welcome to Medicare" preventive visit. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. This visit includes: ▪ a review of your health, ▪ education and counseling about the preventive services you need (including screenings and shots), and ▪ referrals for other care if you need it.	
Well child check-up (also known as Healthchek) Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.	

Preventative Services and Screenings

Services covered by our plan	Limitations and exceptions
Abdominal aortic aneurysm screening The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk.	
Alcohol misuse screening and counseling The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner.	Prior authorization required for more than 12 visits.
Breast cancer screening The plan covers the following services: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms ▪ Annual clinical breast exams	

Services covered by our plan	Limitations and exceptions
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well.	
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.	
Cervical and vaginal cancer screening The plan covers pap tests and pelvic exams annually for all women.	
Colorectal cancer screening For people 50 and older or at high risk of colorectal cancer, the plan covers: ▪ Flexible sigmoidoscopy (or screening barium enema) ▪ Fecal occult blood test ▪ Screening colonoscopy For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	

Services covered by our plan	Limitations and exceptions
Counseling to stop smoking or tobacco use The plan covers tobacco cessation counseling. Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. Unlimited tobacco cessation counseling and classes for pregnant women and children under age 21.	
Depression screening The plan covers depression screening.	
Diabetes screening The plan covers diabetes screening (includes fasting glucose tests). You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).	
HIV screening The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.	

Services covered by our plan	Limitations and exceptions
Immunizations The plan covers the following services: ▪ Vaccines for children under age 21 ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B or Medicaid coverage rules ▪ Other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section C, *Vaccinations*, to learn more.	
Obesity screening and therapy to keep weight down The plan covers counseling to help you lose weight.	Member should talk to primary care doctor or practitioner to find out more.
Prostate cancer screening The plan covers the following services: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test	

Services covered by our plan	Limitations and exceptions
Sexually transmitted infections (STIs) screening and counseling The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B. The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.	

Other Services

Services covered by our plan	Limitations and exceptions
Ambulance and wheelchair van services Covered emergency ambulance transport services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your or, if you are pregnant, your unborn baby's life or health. In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.	Prior authorization required for some ambulette and ambulance transportation. Prior authorization is not required for dialysis services.
Chiropractic services The plan covers: ▪ Diagnostic X-rays ▪ Adjustments of the spine to correct alignment	Prior authorization required for more than 12 visits.

Services covered by our plan	Limitations and exceptions
Dental services The plan covers the following services: ▪ Comprehensive oral exam (one per provider-patient relationship) ▪ Periodic oral exam once every 180 days for members under 21 years of age, and once every 365 days for members age 21 and older ▪ Preventive services including prophylaxis, fluoride, sealants, and space maintainers ▪ Routine radiographs/diagnostic imaging ▪ Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services ▪ One supplemental oral exam and cleaning every year	Some dental services require prior authorization. Please see your dental care provider for details.
Diabetic services The plan covers the following services for all people who have diabetes (whether they use insulin or not): ▪ Training to manage your diabetes, in some cases ▪ Supplies to monitor your blood glucose, including: » Blood glucose monitors and test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan also covers fitting the therapeutic custom-molded shoes or depth shoes.	

Services covered by our plan	Limitations and exceptions
Durable medical equipment and related supplies Covered durable medical equipment includes, but is not limited to, the following: ▪ Wheelchairs ▪ Oxygen equipment ▪ Canes, crutches, and walkers ▪ IV infusion pumps ▪ Hospital beds ▪ Commodes ▪ Nebulizers ▪ Incontinence garments ▪ Enteral nutritional products ▪ Ostomy and urological supplies ▪ Surgical dressings and related supplies For additional types of supplies that the plan covers, see the sections on diabetic services, hearing services, and prosthetic devices. The plan may also cover learning how to use, modify, or repair your item. Your Care Team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan. We will cover all durable medical equipment that Medicare and Medicaid usually cover. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.	Prior authorization required for billed charges over $750.

Services covered by our plan	Limitations and exceptions
Emergency care (see also "urgently needed care") *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, ***and*** ▪ needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: ▪ placing the person's health in serious risk; ***or*** ▪ serious harm to bodily functions; ***or*** ▪ serious dysfunction of any bodily organ or part; ***or*** ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: » There is not enough time to safely transfer the member to another hospital before delivery. » The transfer may pose a threat to the health or safety of the member or unborn child. In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do. Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, contact Member Services to arrange either authorization to stay in the non-network hospital or transition of your care to a participating provider.

Services covered by our plan	Limitations and exceptions
Family planning services The plan covers the following services: ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ▪ Family planning supplies (condom, sponge, foam, film, diaphragm, cap) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions ▪ Treatment for sexually transmitted infections (STIs) ▪ Treatment for AIDS and other HIV-related conditions ▪ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ▪ Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders ▪ Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) **Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.	Prior authorization required for an abortion, and only covered if the mother's life is threatened or in case of reported rape or incest.

Services covered by our plan	Limitations and exceptions
Federally Qualified Health Centers The plan covers the following services at Federally Qualified Health Centers: ▪ Office visits for primary care and specialists services ▪ Physical therapy services ▪ Speech pathology and audiology services ▪ Dental services ▪ Podiatry services ▪ Optometric and/or optician services ▪ Chiropractic services ▪ Transportation services ▪ Mental health services **Note:** You can get services from a network or out-of-network Federally Qualified Health Center.	
Health and wellness education programs You may be eligible to participate in fitness support programs such as Silver Sneakers. Your care manager can provide you with more information.	
Hearing services and supplies The plan covers the following: ▪ Hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) ▪ Hearing aids, batteries, and accessories (including repair and/or replacement) » Conventional hearing aids are covered once every 4 years » Digital/programmable hearing aids are covered once every 5 years	Hearing aids require prior authorization.

Services covered by our plan	Limitations and exceptions
Home and community-based waiver services The plan covers the following home and community-based waiver services: ▪ Adult day health services ▪ Alternative meals service ▪ Assisted living services ▪ Choices home care attendant ▪ Chore services ▪ Community transition ▪ Emergency response services ▪ Enhanced community living services ▪ Home care attendant ▪ Home delivered meals ▪ Home medical equipment and supplemental adaptive and assistive devices ▪ Home modification, maintenance, and repair ▪ Homemaker services ▪ Independent living assistance ▪ Nutritional consultation ▪ Out of home respite services ▪ Personal care services ▪ Pest control ▪ Social work counseling ▪ Waiver nursing services ▪ Waiver transportation	These services are available only if your need for long-term care has been determined by Ohio Medicaid. You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Prior authorization required.

Services covered by our plan	Limitations and exceptions
Home health services The plan covers the following services provided by a home health agency: ▪ Home health aide and/or nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Private duty nursing (may also be provided by an independent provider) ▪ Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally ▪ Medical and social services ▪ Medical equipment and supplies	Prior authorization required.

Services covered by our plan	Limitations and exceptions
Hospice care You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following: ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ▪ Nursing facility care ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:*** ▪ The hospice provider will bill Medicare for your services. Medicare will cover hospice services and any Medicare Part A or B services. You pay nothing for these services. ***For services covered by Medicare Part A or B that are not related to your terminal illness*** (except for emergency care or urgently needed care): ▪ The provider will bill Medicare for your services. Medicare will cover the services covered by Medicare Part A or B. You pay nothing for these services. ***For services covered by CareSource MyCare Ohio but not covered by Medicare Part A or B:*** ▪ CareSource MyCare Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal illness. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. ***This benefit is continued on the next page***	If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Prior authorization required.

Services covered by our plan	Limitations and exceptions
Hospice care (continued) **Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal illness. To reach your care manager, please call **1-866-206-7861**, 24 hours a day, 7 days a week.	
Inpatient behavioral health services The plan covers the following services: ▪ Inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital » For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit ▪ Inpatient detoxification care	Prior authorization required.

Services covered by our plan	Limitations and exceptions
Inpatient hospital care The plan covers the following services, and maybe other services not listed here: ▪ Semi-private room (or a private room if it is medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Costs of special care units, such as intensive care or coronary care units ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Needed surgical and medical supplies ▪ Appliances, such as wheelchairs for use in the hospital ▪ Operating and recovery room services ▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ Blood, including storage and administration ▪ Physician/provider services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplants will be provided through participating MyCareOhio providers. Transplant services may be provided at a distant location outside the service area. If CareSource MyCare Ohio provides transplant services at a distant location outside the service area and you are prior approved to get your transplant there, we will arrange or cover lodging and travel costs for you and one other person.	Prior authorization required.

Services covered by our plan	Limitations and exceptions
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not reasonable and needed, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here: ▪ Doctor services ▪ Diagnostic tests, like lab tests ▪ X-ray, radium, and isotope therapy, including technician materials and services ▪ Surgical dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: » replace all or part of an internal body organ (including contiguous tissue), or » replace all or part of the function of an inoperative or malfunctioning internal body organ. ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition ▪ Physical therapy, speech therapy, and occupational therapy	

Services covered by our plan	Limitations and exceptions
Kidney disease services and supplies The plan covers the following services: ▪ Kidney disease education services to teach kidney care and help you make good decisions about your care ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, *Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan* ▪ Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Note:** Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.	
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan covers three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We cover two hours of one-on-one counseling services each year after that.	

Services covered by our plan	Limitations and exceptions
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. CareSource MyCare Ohio covers the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases ➔ **Chapter 5, *Getting your outpatient prescription drugs through the plan*, explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6, *What you pay for your Medicare and Medicaid prescription drugs*, explains what you pay for your outpatient prescription drugs through our plan.**	

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at addiction treatment centers The plan covers the following services at addiction treatment centers: ■ Ambulatory detoxification ■ Assessment ■ Case management ■ Counseling » Limited to 30 hours per week ■ Crisis intervention ■ Intensive outpatient ■ Alcohol/drug screening analysis/lab urinalysis ■ Medical/somatic » Limited to 30 hours per week ■ Methadone administration ■ Office administered medications for addiction including vivitrol and buprenorphine induction See “Inpatient behavioral health services” and “Outpatient mental health care” for additional information. Services covered include but are not limited to: assessments & testing, pharmacy management & office visits, individual & group counseling, crisis intervention.	Prior authorization is required for: ■ Greater than 10 plan-covered mental health visits per calendar year ■ Intensive outpatient program ■ Partial hospitalization program ■ Inpatient services - see "Hospitalization"

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at community mental health centers The plan covers the following services at certified community mental health centers: ▪ Mental health assessment/diagnostic psychiatric interview » Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year ▪ Community psychiatric supportive treatment (CPST) services ▪ Counseling and therapy » Limited to 52 hours of combined individual/group therapy per year ▪ Crisis intervention ▪ Pharmacological management » Limited to 24 hours per year ▪ Pre-hospital admission screening ▪ Certain office administered injectable antipsychotic medications ▪ Partial hospitalization » Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information. Services covered include but are not limited to: assessments & testing, pharmacy management & office visits, individual & group counseling, crisis intervention.	

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care The plan covers the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment: ▪ A nursing home or continuing care retirement community where you lived on the day you became a CareSource MyCare Ohio member ***This benefit is continued on the next page***	You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Note that patient liability does not apply to Medicare-covered days in a nursing facility (days 1-100). Nursing and skilled nursing facilities require a prior authorization.

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care (continued) You can get Medicare nursing facility care from the following places if they accept our plan's amounts for payment: ▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital	
Outpatient mental health care The plan covers mental health services provided by: ▪ a state-licensed psychiatrist or doctor, ▪ a clinical psychologist, ▪ a clinical social worker, ▪ a clinical nurse specialist, ▪ a nurse practitioner, ▪ a physician assistant, ***or*** ▪ any other qualified mental health care professional as allowed under applicable state laws. The plan covers the following services, and maybe other services not listed here: ▪ Clinic services and general hospital outpatient psychiatric services ▪ Day treatment ▪ Psychosocial rehab services Services covered include but are not limited to: assessments & testing, pharmacy management & office visits, individual & group counseling, crisis intervention.	Prior authorization is required for: ▪ Greater than 10 plan covered mental health visits per calendar year. ▪ Intensive outpatient program ▪ Partial hospitalization program

Services covered by our plan	Limitations and exceptions
Outpatient services The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury. tary enhancement procedures or services (includiServices ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers ▪ Chemotherapy ▪ Labs and diagnostic tests (for example urinalysis) ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ▪ Imaging (for example, X-rays, CTs, MRIs) ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Blood, including storage and administration ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself	Prior authorization required for: ▪ Intensive outpatient program ▪ Partial hospitalization program ▪ CT, CTA, MRI, MRA and PET scans ▪ Outpatient behavior health services more than 10 visits ▪ Partial hospitalization psychiatric services ▪ Cosmetic procedures and plastic surgery

Services covered by our plan	Limitations and exceptions
Physician/provider services, including doctor's office visits The plan covers the following services: ▪ Health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Second opinion by another network provider before a medical procedure ▪ Non-routine dental care. Covered services are limited to: » surgery of the jaw or related structures, » setting fractures of the jaw or facial bones, » pulling teeth before radiation treatments of neoplastic cancer, ***or*** » services that would be covered when provided by a physician.	Some dental services require a prior authorization. Please see your dental care provider for details.
Podiatry services The plan covers the following services: ▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma ▪ Routine foot care for members with conditions affecting the legs, such as diabetes	Prior authorization required for more than 8 visits.

Services covered by our plan	Limitations and exceptions
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. The following are examples of covered prosthetic devices: ▪ Colostomy bags and supplies related to colostomy care ▪ Pacemakers ▪ Braces ▪ Prosthetic shoes ▪ Artificial arms and legs ▪ Breast prostheses (including a surgical brassiere after a mastectomy) ▪ Dental devices The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section for details.	Prior authorization required for billed charges over $750.

Services covered by our plan	Limitations and exceptions
Rehabilitation services ▪ Outpatient rehabilitation services » The plan covers physical therapy, occupational therapy, and speech therapy. » You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist/chiropractor/psychologist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. ▪ Cardiac (heart) rehabilitation services » The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. » The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. ▪ Pulmonary rehabilitation services » The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).	Prior authorization required for: ▪ Greater than 20 occupational therapy visits ▪ Greater than 20 physical therapy visits ▪ Greater than 15 speech therapy visits
Rural Health Clinics The plan covers the following services at Rural Health Clinics: ▪ Office visits for primary care and specialists services ▪ Clinical psychologist ▪ Clinical social worker for the diagnosis and treatment of mental illness ▪ Visiting nurse services in certain situations **Note:** You can get services from a network or out-of-network Rural Health Clinic.	

Services covered by our plan	Limitations and exceptions
Transportation for non-emergency services (see also "Ambulance and wheelchair van services") CareSource MyCare Ohio offers transportation services, if needed. We cover up to 30 round trips per member per calendar year to any health care, Women, Infants and Children (WIC) or redetermination appointments. To arrange a ride, call CareSource MyCare Ohio at **1-855-475-3163**. Please call as soon as you know you need a ride. Please call at least 48 hours (two business days) in advance. If you live in a long-term care facility and you require medical assistance for transport, someone who works at your facility will arrange transportation for you. In addition, if you must travel 30 miles or more from your home to receive covered health care services, CareSource MyCare Ohio will provide transportation to and from the provider's office. This part of the benefit is based on your location and is not subject to the 30 round-trip limit. For more details about our transportation benefit, please see Chapter 3, Section G, *How to get transportation services*. ➔ In addition to the transportation assistance that CareSource MyCare Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.	

Services covered by our plan	Limitations and exceptions
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, ***or*** ▪ a sudden medical illness, ***or*** ▪ an injury, ***or*** ▪ a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.	
Vision care The plan covers the following services: ▪ One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: » per 12-month period for members under 21 and over 59 years of age; ***or*** » per 24-month period for members 21 through 59 years of age. ▪ Vision training ▪ Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: » Treatment for age-related macular degeneration » One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, and members with diabetes » One pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also cover corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant. ▪ One pair of supplemental eyeglasses (lenses and/or frames) covered annually up to $125.	

E. Accessing services when you are away from home or outside of the service area

If you are away from home or outside of our service area (see Chapter 1, Section D, What is CareSource MyCare Ohio's service area?) and need medical care, here are suggestions for what to do.

If it's an **emergency**:

- Call 911 or go to the nearest emergency room

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

- Call your PCP for help for what to do

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

- Call your PCP or
- Call CareSource24, our 24-hour nurse advice line. The phone number is **1-866-206-7861** (TTY for the hearing impaired: 1-800-750-0750 or 711). We can help you decide what to do.

If you need urgent care when you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider in the United States or its territories.

F. Benefits *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not cover these benefits.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not cover the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Medicaid will not cover them either. If you think that we should cover a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages 36-37 for more information on clinical research studies.

Experimental treatment and items are those that are not generally accepted by the medical community.

- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- Full-time nursing care in your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic X-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).

If you have questions, please call CareSource MyCare Ohio at **1-855-475-3163**, Monday – Friday, 8 a.m. – 8 p.m. If you need to speak to your care manager, please call **1-866-206-7861**, 24 hours a day, 7 days a week. These calls are free. **For more information**, visit **CareSource.com/MyCare**.