CareSource

WORKING with *CareSource*

Health Partner Orientation

How to use this presentation

This presentation is an orientation training for all of CareSource's Indiana health partners, including those serving members of:

- Hoosier Healthwise (HHW)
- Healthy Indiana Plan (HIP)
- Marketplace plans (MP)
- Medicare Advantage plans (MA)

We will indicate what plan(s) each slide's information applies to in the upper right hand corner of the slide.

HHW
HIP
MP
MA

About CareSource

OUR MISSION:

To make a **lasting difference** in our members' lives by **transforming** their health and well-being

OUR PLEDGE:

- ✓ Make it easier for you to work with us
- ✓ Partner with providers to help members make healthy choices
- ✓ Direct communication
- ✓ Timely and low-hassle medical reviews
- ✓ Accurate and efficient claims payment

Health Care with Heart

MISSION FOCUSED

Comprehensive, **member-centric** health and life services

EXPERIENCED

With over **27 years of service**, CareSource is a leading non-profit health insurance company

DEDICATED

We serve over **1.5 million members** through our Medicaid, Marketplace, and Medicare Advantage Plans.

25+

YEARS
MISSION-DRIVEN CARE

90%
MEDICAL COST RATIO

A-Z

CONSUMER
ADVOCACY

1.5 MILLION
MEMBERS

COVERAGE
OH, KY, IN, WV
GA – COMING 2017

$14M
FOUNDATION GRANTS AWARDED IN OHIO*

HHW
HIP
MP
MA

CareSource

* The CareSource Foundation currently is only in Ohio

Our Plans

COMMERCIAL HEALTH PLAN	MEDICARE eligible 65+	CHILDREN & PREGNANT WOMEN WITH LOW-INCOME	LOW-INCOME, UNINSURED ADULTS ages 19-64
MARKETPLACE	**MEDICARE ADVANTAGE**	**HOOSIER HEALTHWISE**	**HEALTHY INDIANA PLAN**
Details: • Established 2015 • Qualified health plan • Members may receive reduced premiums or cost-sharing, depending on their income	**Our plans:** • CareSource Advantage® (HMO) • CareSource Advantage Plus ™ (HMO) • CareSource Advantage Zero Premium™ (HMO)	**Details:** • Risk-based managed care • Children up to age 19 • Pregnant women • Low income parents/caretakers with children under 18	**Details:** • For uninsured Hoosiers up to 138% of federal poverty line • Members are responsible for cost sharing by either making a POWER account contribution (PAC) or by copayments. Members who make a PAC receive enhanced benefits.

Members must continue to pay Medicare Part A and B

New for 2017!

HHW HIP MP MA

CareSource

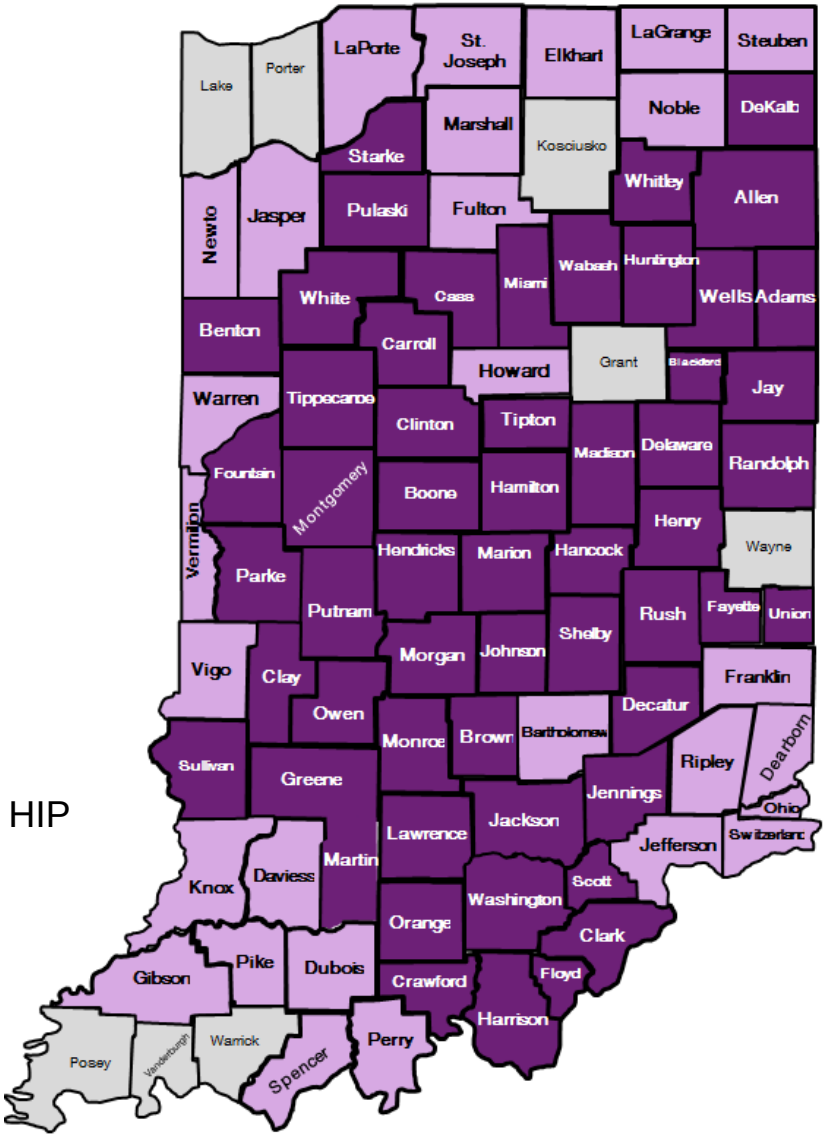
2017 CareSource Coverage

HIGHLIGHTS:

- ✓ We provide services for **Hoosier Healthwise** and **Healthy Indiana Plan** in **ALL** of Indiana
- ✓ We offer our **Medicare Advantage** plans in 57 counties
- ✓ We offer our **Marketplace** plans in 84 counties

LEGEND:

- Marketplace, Medicare Advantage, HHW & HIP
- Marketplace, HHW & HIP
- HHW & HIP only



CareSource

Provider Network

CareSource members choose or are assigned a primary medical provider (PMP) upon enrollment.

When referring patients, ensure other providers are in-network to ensure coverage.

Use our Find A Doc tool at **CareSource.com** to help you locate a participating CareSource provider by plan.

"DO YOU TAKE CARESOURCE?"

With the expansion of CareSource plans, make sure you take the member's plan. Ask to see their IDs at every appointment.

OUT OF NETWORK SERVICES

Out-of-network services are **NOT** covered unless they are emergency services, self-referral services or prior authorized by CareSource.

A provider must be enrolled as an IHCP provider to receive reimbursement for any Medicaid services, including emergency and self-referral services.

Presumptive Eligibility

Provides immediate, temporary coverage for certain groups of individuals who are likely to be eligible for HIP or other Medicaid coverage.

There are three ways to receive temporary health coverage until the FSSA determines official eligibility:

1. Presumptive Eligibility for Pregnant Women (PEPW)
2. Hospital Presumptive Eligibility (Hospital PE)*
3. Presumptive Eligibility (PE)*

Coverage for Hospital PE and PE is the same

TEMPORARY COVERAGE

Those found eligible are allowed temporary health coverage **starting that day**, with benefits equivalent to HIP Basic plan benefits.

- ✓ No POWER Account
- ✓ Still subject to copayments for services, as set forth by Indiana Health Coverage Programs (IHCP)

Presumptive Eligibility

HHW

HIP

Please refer to the table below for categories and determination requirements for different types of presumptive eligibility:

1. Presumptive Eligibility for Pregnant Women (PEPW)
2. Hospital Presumptive Eligibility (Hospital PE)
3. Presumptive Eligibility (PE)

	Presumptive Eligibility for Pregnant Women (PEPW) Process	Hospital PE Process	PE Process
Aid categories	Pregnant women only	• Infants • Children • Pregnant women • Adults 19-64 • Parents/caretakers • Former foster care children • Individuals seeking family planning services	• Infants • Children • Pregnant women • Adults 19-64 • Parents/caretakers • Former foster care children • Individuals seeking family planning services
Qualified providers * In order to be a qualified provider, the provider needs to contact Hewlett Packard Enterprise. Hewlett Packard Enterprise is the responsible entity for processing the presumptive eligibility application.	• Advanced practice nurse practitioners • Family/general practitioners • Certified nurse midwives • General internists • OB/GYNs • FQHCs • RHCs • Medical clinics • Family planning clinics • Local health departments • Hospitals	• Acute care hospitals • Psychiatric hospitals	• FQHCs • RHCs • CMHCs • Local health departments
Enrollment broker requirement	Pregnant women found presumptively eligible must contact the enrollment broker to select a PMP and MCE on the same day a woman is found presumptively eligible	No requirement	No requirement
Delivery system	Managed care	Fee-for-service, except PE Adult, which is managed care	Fee-for-service, except PE Adult, which is managed care

Source: http://provider.indianamedicaid.com/about-indiana-medicaid/member-programs/special-programs/qualified-provider-presumptive-eligibility-(pe).aspx

Notification of Pregnancy

The Indiana Health Coverage Programs (IHCP) recognizes that timely identification of risk factors improves birth outcomes.

The Notification of Pregnancy (NOP) form pinpoints risk factors in the earliest stages of pregnancy for women enrolled in HIP, HHW, Hoosier Care Connect, and women participating in the Presumptive Eligibility (PE) program.

The NOP form may be accessed through the Web interChange (https://interchange.indianamedicaid.com)

REIMBURSEMENT

A qualified provider is eligible for a $60 reimbursement for one NOP per pregnancy completed and successfully submitted using Web interChange. The submitted information is used by CareSource to determine the risk level associated with the pregnancy and establish areas of follow-up care:

Submit claim 99354-TH for $60 if you completed the NOP, but not in the 1st trimester

Submit claim 99354-TH for $70 if you completed the NOP within the 1st trimester

Services Not Covered

- Medically unnecessary services
- Services received from a non-network provider, unless the member has prior authorization
- Experimental or investigational services
- Alternative or complimentary medicine
- Cosmetic procedures or services
- Assisted reproductive therapy

NOTES:

- Bariatric surgery is only covered in our **Medicare Advantage** plans and by HIP Plus for morbid obesity.

Hospice Coverage

HIP members receive hospice coverage.

HHW members must be disenrolled from managed care in order to receive hospice services. The benefit is administered by Indiana. The member must be enrolled in Traditional Medicaid.

CareSource coordinates with IHCP hospice health partners to provide any information needed to complete the hospice election form for the member.

Members must fill out **Medicaid Hospice Election State Form 48737** to enter hospice care.

For much more detail regarding hospice provider enrollment, member eligibility, election/discharge, authorizations, billing and more, we refer you to the **IHCP "Hospice Services" Provider Reference Module**.

School Based Clinics

- For Hoosier Healthwise members
- Support care coordination efforts between school-based clinics and primary medical providers.
- Coordinate health services with schools for members with individualized education plan (IEP) services
- Reimburse school clinics for completion of risk

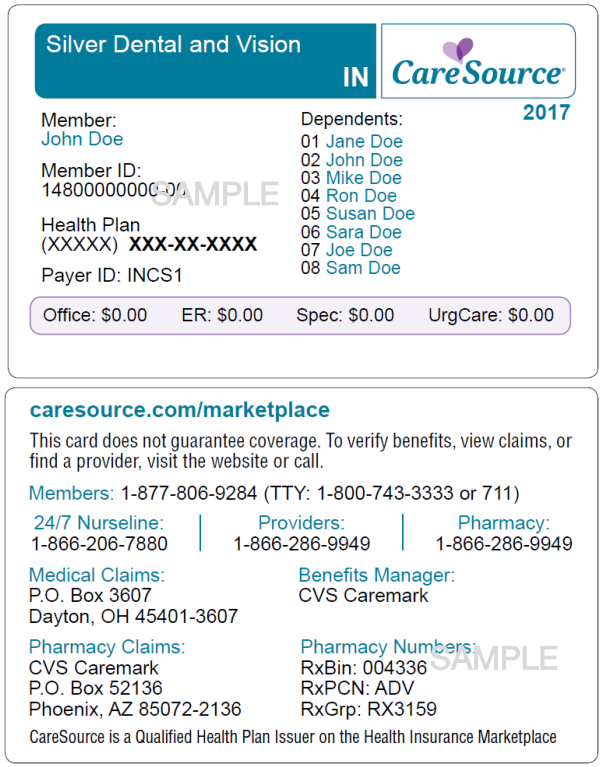
Findings available on the CareSource **Provider Portal**

Marketplace & Medicare Advantage Member ID Cards

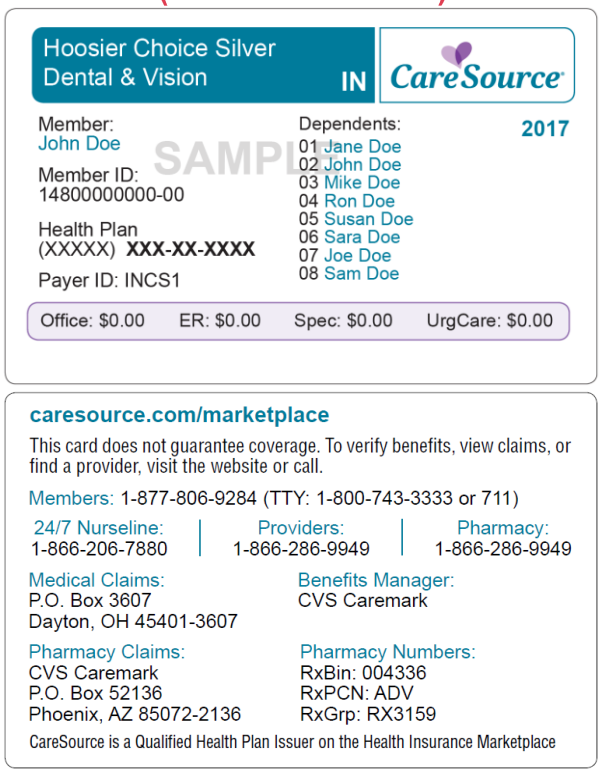
MP

MA

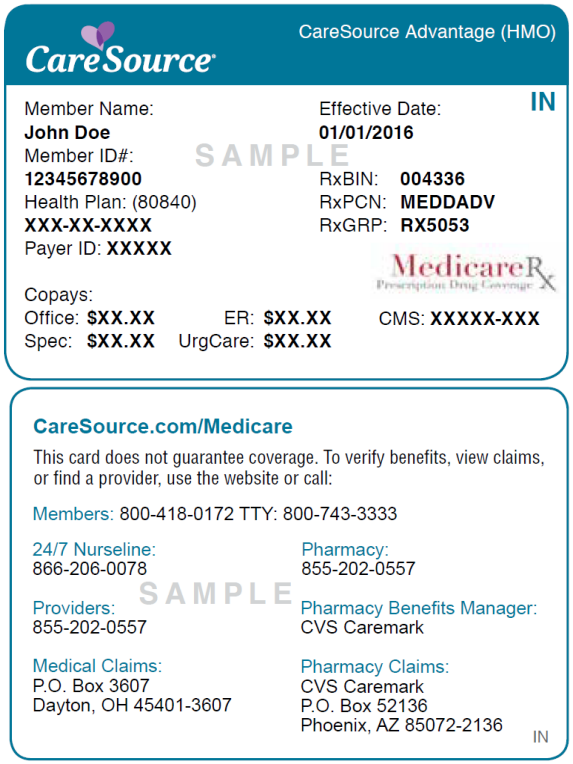
MARKETPLACE



MARKETPLACE (HOOSIER CHOICE)



MEDICARE ADVANTAGE



Marketplace dependents are indicated by the Member ID + suffix

***Example*: 14800000000-01 (Jane Doe)**

Medicare Advantage member's plan will appear in top right corner

HHW Member ID Cards

HOOSIER HEALTHWISE

HOOSIER HEALTHWISE + MATERNITY

HIP Member ID Cards

HEALTHY INDIANA PLAN

HIP MATERNITY

POWER Account

DESCRIPTION:

Health care account for HIP members

AMOUNT:

$2,500 deductible

DEBIT CARD:

HIP members receive a debit card they can use only for covered services by IHCP providers.

HIP Basic and HIP State Plan Basic members are not permitted to use their debit card to pay for services requiring a copayment.

HIP Plus and HIP State Plan Plus members do not pay copayments, with the exception of nonemergent ER services.

WHEN TO CHARGE IT:

Use the POWER Account Treatment Cost calculator to estimate when to charge the card

DO NOT CHARGE FOR:

Members **may not** use their POWER Account Funds to pay for **copayments** or **preventive services**

- Copayments are an out-of-pocket expense for the member
- Preventive services are not eligible for cost sharing

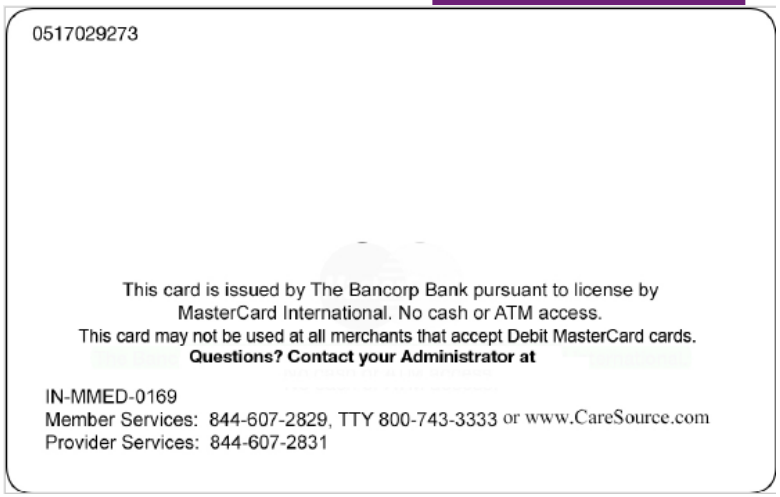
REMEMBER:

A claim must also be submitted to CareSource **for every service**, even if the payment was received via the POWER Account card. Preventive services should not be processed through the POWER Account.

Sample Debit Card

FRONT

BACK



HIP Basic Copayments

Healthy Indiana Plan Basic members are required to make the following copayments at the time services are rendered:

No copayment is required for preventive care, including early periodic screening, diagnostic and testing services, or family planning services.

$4 copayment for outpatient services, including office visits

$75 copayment for inpatient services

$4 copayment for preferred drugs

$8 copayment for non-preferred drugs

*An emergency room visit does not require a copay, unless it is non-emergent:

$8 copayment for initial non-emergency ER visit

$25 copayment for each additional ER visit

Marketplace Member Financial Responsibility

For Marketplace plan members, annual deductible, copayments or coinsurance are applicable for most covered services.

It is up to the provider to collect these amounts at the time of service

Marketplace members have a federally mandated 90 day grace period in which to make their premium payment.

- CareSource will continue to process medical claims and pay providers in those 90 days
- After 30 days, CareSource will flag a member in the eligibility file and on the CareSource Provider Portal
- After 30 days, CareSource will eliminate pharmacy benefits

  If a member pays within 90 days and is reinstated, pharmacy benefits will start again

After 90 days past due, the Marketplace member is terminated for non- payment of premium.

- CareSource will retroactively terminate the member
- CareSource will recover all claims paid for months two and three of delinquency

Provider Resources

	MARKETPLACE	MEDICARE ADVANTAGE	HOOSIER HEALTHWISE HEALTHY INDIANA PLAN
PROVIDER SERVICES	1-866-286-9949	1-855-202-0557	1-844-607-2831
MEDICAL MANAGEMENT FAX	877-716-9480	855-761-9058	844-432-8924
WEBSITE	CareSource.com		
CARESOURCE PROVIDER PORTAL	https://providerportal.caresource.com/IN		
ELECTRONIC FUNDS TRANSFER (EFT)	InstaMed: 1-877-755-3392 (Note dental providers access through dental portal)		
ELECTRONIC CLAIM SUBMISSION	INCS1		
CLAIM ADDRESS	P.O. Box 3607, Dayton, OH 45401-3607		
TIMELY FILING	365 days from date of service or discharge		90 days from date of service or discharge

Claim Submissions

WE ENCOURAGE ELECTRONIC CLAIM SUBMISSION

- Our EFT partner is InstaMed.
- You must enroll with InstaMed to participate.
- Find the enrollment form online and email it to **support@instamed.com**

EDI CLEARINGHOUSES

- CareSource currently accepts electronic claims through the clearinghouses listed below.
- Please contact the clearinghouse of your choice to begin electronic claims submission.

NOTES

- Please list your IHCP Provider Number (also known as Legacy Provider ID/LPI) on all claims
- Please ensure you list the correct billing taxonomy code

CLEARINGHOUSE	WEBSITE	PHONE
Availity (RealMed)	www.availity.com	1-800-AVAILITY
Change Healthcare (formerly Emdeon)	www.changehealthcare.com	1-800-845-6592
Quadax	www.quadax.com	1-440-777-6305
Relay Health	connectcenter.relayhealth.com	1-800-527-8133

CareSource Provider Portal

SAVE TIME. SAVE MONEY. Use CareSource's secure online Provider Portal. With this tool you can:

- Check member eligibility and benefit limits
- Submit claims and verify claim status
- Find prior authorization requirements
- Verify or update Coordination of Benefits information (COB)
- Submit and check the status of a Prior Authorization request
- And more!

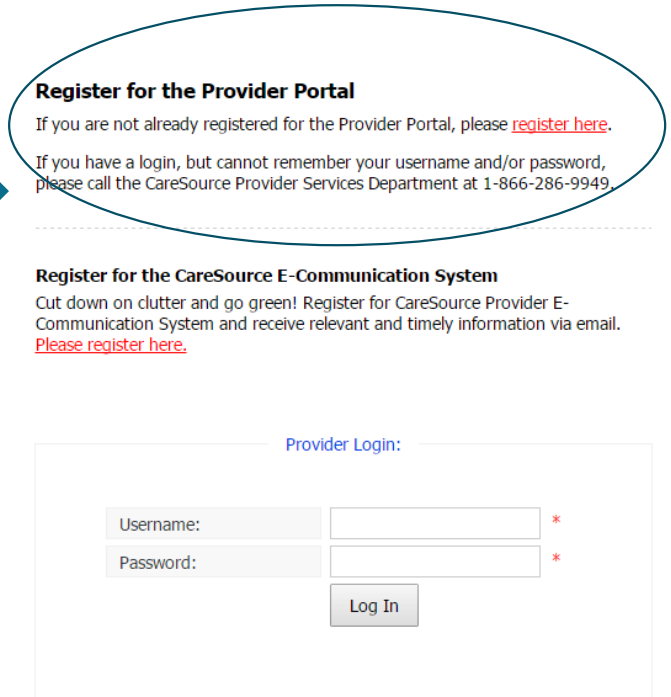
Access the Provider Portal 24 hours a day, 7 days a week, at **CareSource.com.**

Register for the CareSource Provider Portal

Go to **CareSource.com**. On the right side of the page, click on Provider Portal under Provider Resources

Select **Indiana**.

Click register here under **Register for the Provider Portal**.



Enter your information, including your CareSource Provider Number (located in your welcome letter).

Follow remaining steps to register.

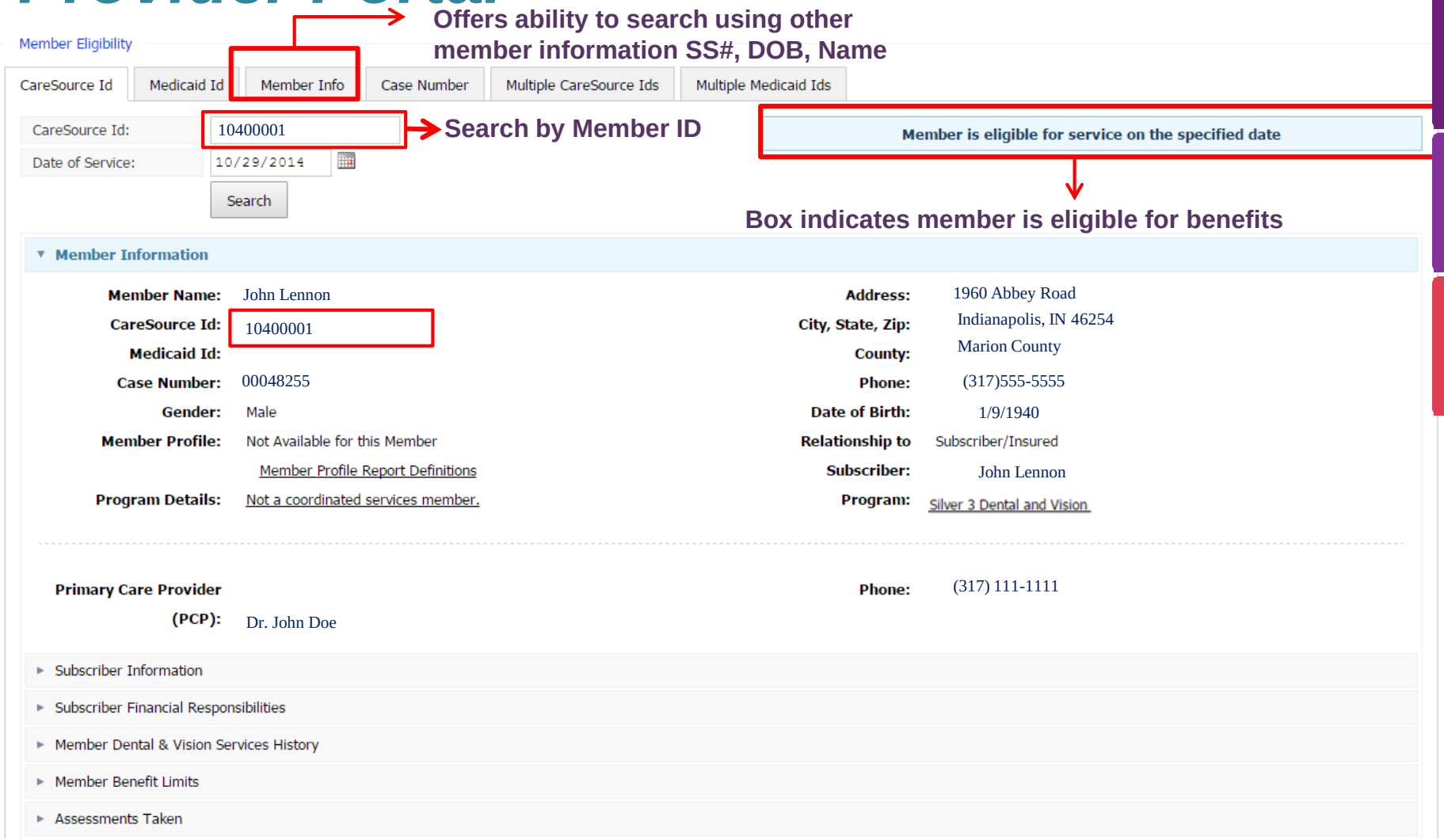
HHW

HIP

MP

MA

Member Eligibility on the CareSource Provider Portal

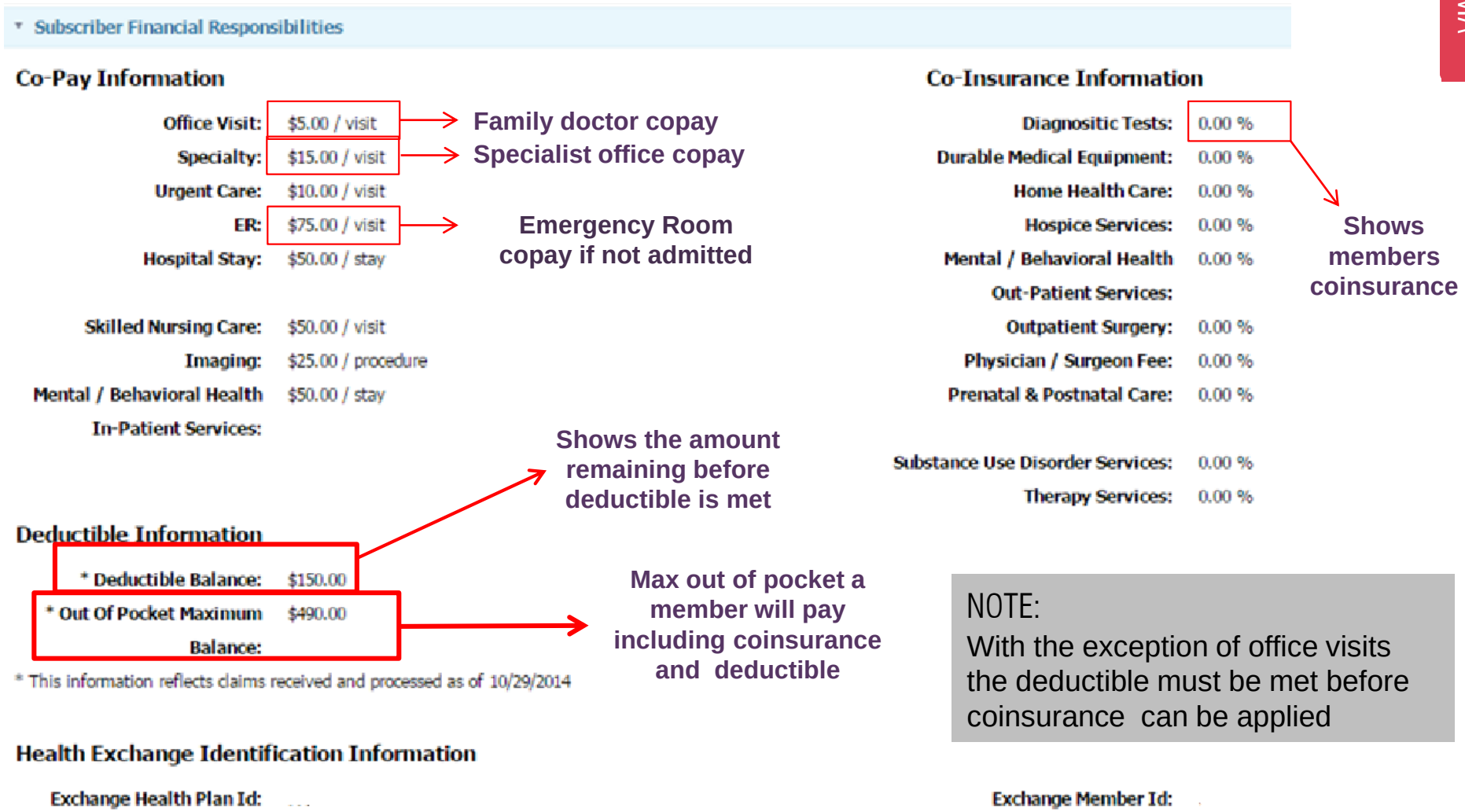


A Past-Due Member on the Provider Portal

Member Benefits on the Provider Portal

MP

MA



Family doctor copay

Specialist office copay

Emergency Room copay if not admitted

Shows members coinsurance

Shows the amount remaining before deductible is met

Max out of pocket a member will pay including coinsurance and deductible

NOTE:
With the exception of office visits the deductible must be met before coinsurance can be applied

Prior Authorization Requests

	MARKETPLACE	MEDICARE ADVANTAGE	HOOSIER HEALTHWISE HEALTHY INDIANA PLAN
ONLINE	At **CareSource.com** through Provider Portal		
EMAIL	**mmauth@CareSource.com**		**inmedmgmt@caresource.com**
PHONE	1-866-286-9949	1-855-202-0557	1-844-607-2831
FAX	877-716-9480	855-761-9058	844-432-8924
MAIL	CareSource Medical Management P.O. Box 1307 Dayton, OH 45401-1307	CareSource Medical Management P.O. Box 3209 Dayton, OH 45401-3209	CareSource Medical Management P.O. Box 743 Dayton, OH 45401

PA Information Checklist

When you request authorization (PA), be sure to include:

- Member/patient name and CareSource member ID number
- Provider name and NPI
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of the service
- Inpatient services need to include whether the service is elective, urgent, or emergency, admitting diagnosis, symptoms & plan of treatment

You will have 180 days from the date of service, date of discharge, or 90 days from the other carrier's EOB (whichever is later) for retrospective authorization

REFERRALS

We ***do not*** require a referral to see a specialist. However, prior authorizations may still be required for services provided by specialists.

WHERE DO I FIND MORE INFORMATION?

You can find more information in our **Health Partner Manual**, located at **CareSource.com**.

Services Requiring Prior Authorization

- All services provided out-of-network
- Inpatient services
- Partial hospitalization programs
- Intensive outpatient behavioral health services
- All surgical services
- Advanced diagnostic imaging through NIA Magellan (i.e. PET, MRI, MRA, CT etc.,)
- Certain outpatient procedures and tests as specified by PA list on the Provider Portal
- Purchase or rental of specified medical supplies, durable medical equipment (DME) supplies or appliance, as well as items exceeding $750.
- Skilled nursing facilities
- Home infusion therapy
- Accidental dental (reconstruction due to accident)
- Pain management services
- Behavioral health facility: Inpatient and outpatient including alcohol and substance abuse

Log in to the **Provider Portal** at **CareSource.com** to view a more comprehensive list of covered services and limitations.

Prior authorization of a service does not guarantee payment. The service must be a covered benefit in the member's plan.

Retrospective authorization is not the same as a retrospective prior authorization request.

HHW

HIP

Self-Referral Services

CareSource includes self-referral health partners in our networ
For both HHW and HIP, members may self-refer to any IHCP-enrolled provider for the services eligible for self-referral.

HHW MEMBERS :

May receive self-referral services from IHCP-enrolled self-referral health partners who are not in the Caresource network

CareSource reimburses self-referral services up to the applicable benefit limits and at IHCP FFS rates

HIP MEMBERS

- Must go to an in-network health partner; **OR**
- Receive PA from CareSource to go to an out-of-network health partner

Exceptions: Family planning & emergency services

CareSource reimburses self-referral services up to the applicable benefit limits and at a rate not less than the Medicare rate, or at 130 % of Medicaid if no Medicare rate

Self-Referral Services

The following services are eligible for self-referral:

- Psychiatric services
- Family planning services

The following services are eligible for self-referral, but may only be provided to members receiving services through Hoosier Healthwise, HIP State Plan, or while receiving the additional HIP pregnancy-only benefits.

- Chiropractic services
- Eye care services, except surgical services
- Routine dental services
- Podiatric services

The Indiana Administrative Code 405 IAC 5 (Hoosier Healthwise) and 405 IAC 9-7 (Healthy Indiana Plan) provide further detail.

Prior Authorization
NIA Magellan Imaging

For all plans, CareSource utilizes NIA Magellan to implement a radiology benefit management program for outpatient advanced imaging services.

Procedures requiring prior authorization through NIA Magellan:	Services NOT requiring prior authorization through NIA Magellan:	NIA Magellan authorization phone number:
• CT/CTA • MRI/MRA • PET Scan	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services	• Marketplace: **1-800-424-5660** • Medicare Advantage: **1-800-424-1741** • HHW/HIP: **1-800-424-4883**.

Expedited authorizations are accepted. Register at **RadMD.com**

NIA Magellan Provider Relations Manager:
April J. Sidwa | 410-953-1078 | ajsidwa@magellanhealth.com

More resources on NIA Magellan imaging may be found at **CareSource.com/Providers**

QUALITY IMPROVEMENT *Initiatives*

CareSource encourages you to actively participate in Centers for Medicare & Medicaid Services (CMS) and U.S. Department of Health and Human Services (HHS) quality improvement initiatives.

Quality Measures for Marketplace and HHW/HIP

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set (HEDIS®) and Medicare Consumer Assessment of Health Providers and Systems (CAHPS®).

Potential quality measures are, but not limited to:

- **Wellness and prevention:**
  - Preventative screenings (breast cancer, cervical cancer and chlamydia screenings)
  - Well-child care
- **Chronic disease management:**
  - Comprehensive diabetes care
  - Controlling high blood pressure
- **Behavioral health:**
  - Follow-up after hospitalization for mental illness
  - Antidepressant medication management
  - Follow-up for children prescribed ADHD medication
- **Safety:**
  - Use of imaging studies for lower back pain

Potential CAHPS measures include:

- **Customer service**
- **Getting care quickly**
- **Getting needed care**
- **How well doctors communicate**
- **Ratings of all health care, health plans, personal doctors and specialists**

HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS® is developed and maintained by The National Committee for Quality Assurance (NCQA). The HEDIS® tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS® benchmarks. HEDIS® measures are based on evidence-based care and address the most pressing areas of care.

Quality Measures for Medicare Advantage

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis, and the annual review of the Medicare Healthcare Effectiveness Data and Information Set (HEDIS®), Health Outcomes Survey (HOS), and Medicare Consumer Assessment of Health Providers and Systems (CAHPS®). Medicare HEDIS®, HOS, and Medicare CAHPS® form the basis for the Centers for Medicare& Medicaid Services (CMS) Star Ratings used to evaluate the quality of care provided to CareSource Medicare Advantage members. CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plan and the health care system.

CMS star ratings are based on health plans' ratings across five categories:

1. **Staying healthy:** screenings, tests, & vaccines to help members stay healthy
2. **Managing chronic (long-term) conditions:** how often members with chronic conditions get tests & treatments to manage their condition
3. **Member experience with the health plan:** member satisfaction ratings with the plan
4. **Member complaints & changes in the health plan's performance:** how often Medicare found problems with the plan & how often members had problems with the plan
5. **Health plan customer service:** how well the plan handles member appeals

Health plans covering drug services are measured on services in four categories:

1. **Drug plan customer service:** how well the plan handles member appeals
2. **Member complaints & changes in the drug plan's performance:** how often Medicare found problems with the plan & how often members had problems with the plan
3. **Member experience with plan's drug services:** member satisfaction ratings with the plan
4. **Drug safety & accuracy of drug pricing:** how accurate the plan's pricing information is & how often members with certain medical conditions are prescribed drugs in a way that is safe & clinically recommended for their condition

Care and Disease Management

WE CAN HELP:

- Coordinate medications
- Provide education
- Arrange follow-up services
- Reduce readmission risks

PLEASE HELP by identifying patients who may need individualized attention to help them manage their complex health care needs.

REFERRING A PATIENT

You may refer a patient for care or disease management in the following ways:

ONLINE

CareSource.com through the Provider Portal

CALL:

- **Marketplace**: 1-855-202-0415
- **Medicare Advantage:** 1-866-415-0585
- **HHW/HIP**: 1-844-607-2829

Cultural Competency

Health partners are expected to provide services in a culturally competent manner, including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic, and social needs of members
- Meeting the requirements of all applicable State and federal laws

RESOURCES

We provide cultural competency training sources in the Health Partner Manual and online at **CareSource.com.**

Medical Records

You must maintain medical and other records of all medical services provided our members for seven years, in accordance with Indiana Code (IC) 16-39-7-1.

CareSource medical records standards are consistent, to the extent feasible, with NCQA accreditation standards for medical records.

STANDARDS

For full medical record standards, please see the Health Partner Manual.

Pharmacy Overview

- PARTNERSHIP WITH CVS
  - CVS Caremark is the delegated pharmacy benefit manager for CareSource

MARKETPLACE	MEDICARE ADVANTAGE	HHW/HIP
Phone: **1-800-364-6331**	Phone: **1-800-202-1059**	Phone: **1-800-364-6331**
Fax: 866-930-0019	Fax: 855-633-7673	Fax: 866-930-0019

- SPECIALTY DRUGS
  - CVS Specialty Pharmacy provides all specialty medications
- E-PRESCRIBING
  - Once providers are set up through CVS Caremark, they are ready to prescribe electronically
- RESOURCES
  - Authorization requirements for prescriptions may be found on your plan's Provider pages under the Pharmacy section.
  - Formulary Search Tool and Prior Authorization lists are available on **CareSource.com** under Member Documents
  - MTM (Medication Therapy Management) – allows pharmacists to work collaboratively with physicians

Member Resource Page

Help your CareSource patients understand their insurance coverage.

Encourage them to visit our website, where they can access**:**

- Searchable online formulary
- Find a Doctor/Provider tool
- Evidence of coverage
- Member handbook
- Forms
- And more

CareSource.com/Members

Marketplace Plans Pharmacy Benefit Structure

TIERED MEDICATION STRUCTURE

The higher the tier, the higher the cost of the drug. Access PDL online at **CareSource.com**

TIER 0	TIER 1	TIER 2	TIER 3	TIER 4	TIER 5
Prescription drugs, include preventive medications. These medications are available without a copayment or coinsurance.	**Contains low-cost generic drugs.**	**Higher coinsurance or copayment than those in Tier 1.** This tier contains preferred medications that may be generic drugs or single- or multi-source brand-name drugs.	**Higher coinsurance or copayment than those in Tier 2.** This tier contains non-preferred medications. Includes medications considered single- or multi-source brand-name drugs.	**Higher coinsurance or copayment than those in Tier 3.** Medications generally classified as preferred medications fall in this category	**Higher coinsurance than those in Tier 4.** Medications generally classified as specialty non-preferred medications fall into this category.

Visit the Pharmacy page at **CareSource.com** if you wish to access our full formulary list.

Medicare Advantage Pharmacy Benefit Structure

TIERED MEDICATION STRUCTURE

The higher the tier, the higher the cost of the drug. Access PDL online at **CareSource.com**

TIER 1	TIER 2	TIER 3	TIER 4	TIER 5
Preferred generic drugs.	**Higher cost than Tier 1.**	**Higher cost than Tier 2.**	**Higher cost than Tier 3.**	**Highest cost tier.**
Lowest cost tier. Includes preferred generic medications.	Includes non-preferred generic drugs.	Includes preferred brand medications.	Includes non-preferred brand medications.	Includes brand and generic specialty medications.

Visit the Pharmacy page at **CareSource.com** if you wish to access our full formulary list.

HHW & HIP Pharmacy Benefit Structure

HHW

HIP

HOOSIER HEALTHWISE

PACKAGE A (STANDARD PLAN)	No copays
PACKAGE C (CHILDREN'S PLAN)	Copays apply
PACKAGE P (PREGNANCY PRESUMPTIVE ELIGIBILITY)	No copays

HEALTH INDIANA PLAN

HIP BASIC	Copays apply
HIP PLUS	No copays*
STATE BASIC PLAN	Copays apply
STATE PLAN PLUS	No copays

*A copayment applies when a HIP Plus member uses the emergency room for a nonemergency

2017 Marketplace Medical Benefits

	Gold	Silver Limited	Silver 1	Silver 2	Silver 3	Bronze	Zero Plans
Deductible	**$1,000**	**$3,300**	**$3,250**	**$950**	**$350**	**$6,650**	**$0**
Coinsurance	**20%** after deductible	**30%** after deductible	**30%** after deductible	**15%** after deductible	**5%** after deductible	**40%** after deductible	**$0**
Maximum Out-of-Pocket (Combined unless noted otherwise)	**$2,500** Medical **$2,000** Pharmacy	**$6,400**	**$5,500**	**$1,900**	**$650**	**$6,850**	**$0**
Emergency Room Services	**$250** after deductible	**$500** after deductible	**$350** after deductible	**$350** after deductible	**$325** after deductible	**$500** after deductible	**$0**
Primary Care visit	**$0**	**$0**	**$0**	**$0**	**$0**	**$35**	**$0**
Specialist Visit	**$40**	**$50**	**$40**	**$10**	**$0**	**$75**	**$0**
Imaging (CT/PET Scans, MRIs)	**$150** after deductible	**$175** after deductible	**$160** after deductible	**$125** after deductible	**$125** after deductible	**$200** after deductible	**$0**
Urgent Care	**$75**	**$75**	**$75**	**$0**	**$0**	**$100**	**$0**

2017 Federal Standard Marketplace Medical Benefits

Effective 2017: CareSource, in compliance with guidelines from The Centers for Medicare and Medicaid (CMS), will offer Federal Standard Marketplace plans. This simplifies the shopping experience for Marketplace consumers.

	Simple Choice Gold	Simple Choice Silver Limited	Simple Choice Silver 1	Simple Choice Silver 2	Simple Choice Silver 3	Simple Choice Bronze	Simple Choice Zero Plans
Deductible	**$1,250**	**$3,500**	**$3,000**	**$700**	**$250**	**$6,650**	**$0**
Coinsurance	**20%** after deductible	**20%** after deductible	**20%** after deductible	**20%** after deductible	**5%** after deductible	**50%** after deductible	**$0**
Maximum Out-of-Pocket (Combined unless noted otherwise)	**$4,750** Medical **$1,500** Pharmacy	**$7,150**	**$5,700**	**$2,000**	**$1,250**	**$7,150**	**$0**
Emergency Room Services	**$250** after deductible	**$400** after deductible	**$300** after deductible	**$150** after deductible	**$100** after deductible	**50%** after deductible	**$0**
Primary Care visit	**$20**	**$30**	**$30**	**$10**	**$5**	**$45**	**$0**
Specialist Visit	**$50**	**$65**	**$65**	**$25**	**$15**	**50%** after deductible	**$0**
Imaging (CT/PET Scans, MRIs)	**20%** after deductible	**20%** after deductible	**20%** after deductible	**20%** after deductible	**5%** after deductible	**50%** after deductible	**$0**
Urgent Care	**$65**	**$75**	**$75**	**$40**	**$25**	**50%** after deductible	**$0**

2017 Medicare Advantage Benefits

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Monthly Premium	**$32.10** Members must continue to pay Part B premium	**$56.60** Members must continue to pay Part B premium	**$0** Members must continue to pay Part B premium
Deductible	$0	$0	$400
Prescription Deductible	$0	$0	$250
Maximum Out-of-Pocket	$4,600	$4,600	$6,700
Emergency Room Services	$75 copay	$75 copay	$75 copay
Primary Care visit	$0 copay	$0 copay	$10 copay
Specialist Visit	$50 copay	$30 copay	$50 copay
Urgent Care	$35 copay	$25 copay	$65 copay
Outpatient Lab Services	$0	$0	$0
Physical & Speech Therapy	$40 copay	$25 copay	20% after deductible
Occupational Therapy	$40 copay	$30 copay	20% after deductible
PERS – Personal Emergency Response System	✖		✖

Members receive all the benefits of Medicare Part A and Part B, plus prescription drug coverage (Part D)

HHW & HIP Benefits

HHW & HIP BENEFITS OVERVIEW:

- ✓ PCP and specialist office visits
- ✓ ER services
- ✓ Inpatient hospital
- ✓ Mental health and substance abuse services
- ✓ Urgent care
- ✓ Family planning
- ✓ Diagnostic services (ex: lab & radiology)
- ✓ Preventative services (routine well visits and screenings)
- ✓ Maternity services
- ✓ Pharmacy

HIP PLUS ONLY:

- ✓ Vision services
- ✓ Dental – no limitations on fillings or extractions

ENHANCED BENEFITS:

- ✓ Life Services
- ✓ Non-emergent transportation (additional above NET, for certain special populations)
- ✓ HELP4U
- ✓ Wellness & disease management
- ✓ Smartphones
- ✓ Text4Babies
- ✓ Medication therapy management
- ✓ Boys & Girls Club membership (ages 6 – 18) at **no cost** to the member
- ✓ Girl Scout membership (grades K – 8) at **no cost** to the member

Fraud, Waste & Abuse Program

HHW
HIP
MP
MA

Help CareSource stop fraud.

Contact us to report any suspected fraudulent activities:

CALL:

Marketplace: 1-866-286-9949
Medicare: 1-855-202-0557
HHW/HIP: 1-844-607-2831

EMAIL:

fraud@caresource.com

FAX:

800-418-0248

MAIL:

CareSource
Attention: Special Investigations Unit
P.O. Box 1940
Dayton, OH 45401-1940

How to Reach Us

	MARKETPLACE	MEDICARE ADVANTAGE	HOOSIER HEALTHWISE HEALTHY INDIANA PLAN
PROVIDER SERVICES	1-866-286-9949	1-855-202-0557	1-844-607-2831
HOURS	Monday – Friday, 8 a.m. – 6 p.m. EST		Monday – Friday, 8 a.m. – 8 p.m. EST
MEMBER SERVICES	1-877-806-9284	1-800-418-0172	1-844-607-2829
HOURS	Monday – Friday, 7 a.m. – 7 p.m. EST	Monday – Friday, 8 a.m. – 8 p.m. EST From Oct. 1 – Feb. 1, we are open the same hours 7 days a week	Monday – Friday, 8 a.m. – 8 p.m. EST

HHW

HIP

MP

MA

Health Partner Engagement Specialists

As a CareSource health partner, you are supported by our Health Partner Engagement Specialist team. Whatever your question, they are here to help.

EMAIL	IN_Provider_Relations@caresource.com
PHONE/VOICEMAIL	317-982-6480
E-FAX	937-396-3989

Visit **CareSource.com** for an up-to-date map with your assigned health partner engagement representative.

Health Partner Resources

Visit the **CareSource.com** Plan Resources page to access the following resources**:**

- Printable Health Partner Manual
- Printable orientation slides
- Formularies
- Covered benefits
- Quick reference guides
- And more

CareSource Provider Portal:
https:providerportal.caresource.com/IN

CareSource.com/Providers

HHW
HIP
MP
MA

PARTNERS with *Purpose*

Are you contracted with all our plans? **Join us** on the next journey to healthy outcomes in Indiana.

Visit **CareSource.com/Contracting** to start the contracting process.

Thank you!

Questions?