CareSource Advantage® (HMO SNP)

# Summary of Benefits

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CareSource

# *CareSource Advantage (HMO SNP)*

# 2012 Summary of Benefits

**For Contract H6178, Plan 001**

*Section I*

**Introduction to the Summary of Benefits**

**For CareSource Advantage (HMO SNP)**

**January 1, 2012 – December 31, 2012**

**Entire State of Ohio**

Thank you for your interest in **CareSource Advantage** (HMO SNP). Our plan is offered by **CareSource**, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria.

You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this Summary of Benefits is based on your level of Medicaid eligibility.

Please call CareSource Advantage (HMO SNP) to find out if you are eligible to join. Our number is listed at the end of this introduction.

This Summary of Benefits tells you some features of our plan. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call CareSource Advantage (HMO SNP) and ask for the "Evidence of Coverage."

## YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like CareSource Advantage (HMO SNP). You may have other options, too. You make the choice. No matter what you decide, you are still in the Medicare program.

If you are eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call CareSource Advantage (HMO SNP) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

## HOW CAN I COMPARE MY OPTIONS?

You can compare CareSource Advantage (HMO SNP) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

**WHERE IS CARESOURCE ADVANTAGE (HMO SNP) AVAILABLE?**

The service area for this plan includes all counties in Ohio. You must live in this area to join the plan.

**WHO IS ELIGIBLE TO JOIN CARESOURCE ADVANTAGE (HMO SNP)?**

You can join CareSource Advantage (HMO SNP) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease generally are not eligible to enroll in CareSource Advantage (HMO SNP) unless they are members of our organization and have been since their dialysis began.

You must also receive assistance from the state to join this plan.

Please call the plan to see if you are eligible to join.

**CAN I CHOOSE MY DOCTORS?**

CareSource Advantage (HMO SNP) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current Provider Directory. For an updated list, visit us at www.caresource.com. Our customer service number is listed at the end of this introduction.

**WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

**WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

CareSource Advantage (HMO SNP) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a Pharmacy Directoy or visit us at www.caresource.com. Our customer service number is listed at the end of this introduction.

**DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

CareSource Advantage (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

**WHAT IS A PRESCRIPTION DRUG FORMULARY?**

CareSource Advantage (HMO SNP) uses a formulary. A formulary is a list of drugs covered by your plan to meet patients' needs. We may periodically add, remove, or

make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.caresource.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

**HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?**

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week, and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication *Medicare & You*;
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or
- Your State Medicaid Office.

**WHAT ARE MY PROTECTIONS IN THIS PLAN?**

All Medicare Advantage Plans agree to stay in the program for a full calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue for an additional calendar year, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of CareSource Advantage (HMO SNP), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of CareSource Advantage (HMO SNP), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

**WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?**

A Medication Therapy Management (MTM) Program is a free service we offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact CareSource Advantage (HMO SNP) for more details.

**WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?**

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact CareSource Advantage (HMO SNP) for more details.

- **Some Antigens:** If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- **Osteoporosis Drugs:** Injectable drugs for osteoporosis for certain women with Medicare.
- **Erythropoietin (Epoetin Alfa or Epogen®):** By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- **Hemophilia Clotting Factors:** Self-administered clotting factors if you have hemophilia.
- **Injectable Drugs:** Most injectable drugs administered incident to a physician's service.
- **Immunosuppressive Drugs:** Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- **Some Oral Cancer Drugs:** If the same drug is available in injectable form.
- **Oral Anti-Nausea Drugs:** If you are part of an anti-cancer chemotherapeutic regimen.

- **Inhalation and Infusion Drugs administered through DME.**

## WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select “Health & Drug Plans” then “Compare Drug and Health Plans” to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call CareSource for more information about CareSource Advantage (HMO SNP).

Visit us at www.caresource.com or call us:

- Customer Service Hours: Monday – Friday, 8:00 a.m. - 8:00 p.m. Eastern

- Current and Prospective members should call toll-free (800) 708-8729 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD (800) 750-0750 or 711).

- Current and Prospective members should call locally (800) 708-8729 for questions related to the Medicare Advantage Program or the Medicare Part D Prescription Drug program. (TTY/TDD (800) 750-0750 or 711).

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227 or TTY/TDD 1-877-486-2048). You can call 24 hours a day, 7 days a week. Or visit www.medicare.gov on the web.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

***Section II***

# Summary of Benefits Report

(For Contract H6178, Plan 001)

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| **Important Information** | | |
| 1 – Premium and Other Important Information | The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.<br><br>In 2011, the monthly Part B Premium was $0 or $96.40 and may change for 2012 and the annual Part B deductible amount was $0 or $162 and may change for 2012.*<br><br>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. | *General*<br>* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services.<br><br>** Please consult with your plan about cost sharing when receiving services from out-of-network providers.<br><br>$0 monthly plan premium in addition to your monthly Medicare Part B premium.*<br><br>*In-Network*<br>In 2011, the annual Part B deductible amount was $0 or $162 and may change for 2012.* Contact the plan for services that apply.<br><br>$6,700 out-of-pocket limit. All plan services included.* |
| 2 – Doctor and Hospital Choice<br><br>(For more information, see Emergency Care - #15 and Urgently Needed Care - #16.) | You may go to any doctor, specialist or hospital that accepts Medicare. | *In-Network*<br>You must go to network doctors, specialists, and hospitals.<br><br>No referral required for network doctors, specialists, and hospitals. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| **Inpatient Care** | | |
| 3 – Inpatient Hospital Care<br><br>(includes Substance Abuse and Rehabilitation Services) | In 2011, the amounts for each benefit period were, $0 or:<br>Days 1-60: $1,132 deductible*<br>Days 61-90: $283 per day*<br>Days 91-150: $566 per lifetime reserve day*<br><br>These amounts may change for 2012.<br><br>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once.<br><br>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | *In-Network*<br>Plan covers 90 days each benefit period.<br><br>In 2011, the amounts for each benefit period were,<br>$0 or:<br>Days 1-60: $1,132 deductible*<br>Days 61-90: $283 per day*<br>Days 91-150: $566 per lifetime reserve day*<br><br>These amounts may change for 2012.<br><br>You will not be charged additional cost sharing for professional services.<br><br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. |
| 4 – Inpatient Mental Health Care | In 2011, the amounts for each benefit period were, $0 or:<br>Days 1-60: $1,132 deductible*<br>Days 61-90: $283 per day*<br>Days 91-150: $566 per lifetime reserve day.*<br><br>These amounts may change for 2012. | *In-Network*<br>In 2011, the amounts for each benefit period were, $0 or:<br>Days 1-60: $1,132 deductible*<br>Days 61-90: $283 per day*<br>Days 91-150: $566 per lifetime reserve day.*<br><br>These amounts may change for 2012.<br><br>You get up to190 days of inpatient |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | You get up to190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. | psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.<br><br>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. |
| 5 – Skilled Nursing Facility (SNF)<br><br>(in a Medicare-certified skilled nursing facility) | In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were:<br><br>Days 1-20: $0 per day*<br>Days 21-100: $0 or $141.50 per day.*<br><br>These amounts may change for 2012.<br><br>100 days for each benefit period.<br><br>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>Plan covers up to 100 days each benefit period.<br><br>No prior hospital stay is required.<br><br>In 2011, the amounts for each benefit period were:<br>$0 or:<br>Days 1-20: $0 per day*<br>Days 21-100: $141.50 per day.*<br><br>These amounts may change for 2012.<br><br>You will not be charged additional cost sharing for professional services. |
| 6 – Home Health Care (includes medically necessary intermittent | $0 copay. | *General*<br>Authorization rules may apply. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| skilled nursing care, home health aide services, and rehabilitation services, etc.) | | *In-Network*<br>$0 copay for Medicare-covered home health visits.* |
| 7 - Hospice | You pay part of the cost for outpatient drugs and you may pay part of the cost for inpatient respite care. You must get care from a Medicare-certified hospice. | *General*<br>You must get care from a Medicare-certified hospice. Your plan will pay for a consultative visit before you select hospice. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| **Outpatient Care** | | |
| 8 – Doctor Office Visits | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>$0 copay for each primary care doctor visit for Medicare-covered benefits.*<br><br>0% or 20% of the cost for each in-area, network urgent care Medicare-covered visit.*<br><br>0% or 20% of the cost for each specialist visit for Medicare-covered benefits.* |
| 9 – Chiropractic Services | Supplemental routine care not covered<br><br>0% or 20% coinsurance for manual manipulation of the spine to correct subluxation (a displace-ment or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for each Medicare-covered visit.*<br><br>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers. |

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|---|---|---|
| 10 – Podiatry Services | Supplemental routine care not covered.<br><br>0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for each Medicare-covered visit.*<br><br>Medicare-covered podiatry benefits are for medically-necessary foot care. |

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|---|---|---|
| 11 – Outpatient Mental Health Care | 0% or 40% coinsurance for most outpatient mental health services.<br><br>0% or 40% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.<br><br>"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 40% of the cost for each Medicare-covered individual therapy visit.*<br><br>0% or 40% of the cost for each Medicare-covered group therapy visit.*<br><br>0% or 40% of the cost for each Medicare-covered individual therapy visit with a psychiatrist.*<br><br>0% or 40% of the cost for each Medicare-covered group therapy visit with a psychiatrist.*<br><br>0% or 20% of the cost for Medicare-covered partial hospitalization program services.* |
| 12 – Outpatient Substance Abuse Care | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for Medicare-covered individual therapy visits.*<br><br>0% or 20% of the cost for Medicare-covered group visits.* |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| 13 – Outpatient Services/Surgery | 0% or 20% coinsurance for the doctor's services.<br><br>Specified copayment for outpatient hospital facility services. Copay cannot exceed the Part A inpatient hospital deductible.<br><br>0% or 20% coinsurance for ambulatory surgical center facility services. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit.*<br><br>0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit.* |
| 14 – Ambulance Services<br><br>(medically necessary ambulance services) | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for Medicare-covered ambulance benefits.* |
| 15 – Emergency Care<br><br>(You may go to any emergency room if you reasonably believe you need emergency care.) | 0% or 20% coinsurance for the doctor's services.<br><br>Specified copayment for outpatient hospital facility emergency services.<br><br>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.<br><br>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient for the same condition within 3 days of the emergency room visit.<br><br>Not covered outside the U.S. except under limited circumstances. | *General*<br>0% or 20% of the cost (up to $65) for Medicare-covered emergency room visits.*<br><br>This amount applies toward your in and out-of-network plan deductible.<br><br>Not covered outside the U.S. except under limited circumstances. Contact the plan for more details.<br><br>If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| 16 – Urgently Needed Care<br><br>(This is NOT emergency care, and in most cases, is out of the service area.) | 0% or 20% coinsurance<br><br>NOT covered outside the U.S. except under limited circumstances. | *General*<br>0% or 20% of the cost for Medicare-covered urgently-needed-care visits.* |
| 17 – Outpatient Rehabilitation Services<br><br>(Occupational Therapy, Physical Therapy, Speech and Language Therapy) | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits.<br><br>0% or 20% of the cost for Medicare-covered Occupational Therapy visits.*<br><br>0% or 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits.* |
| **Outpatient Medical Services and Supplies** | | |
| 18 – Durable Medical Equipment<br><br>(includes wheelchairs, oxygen, etc.) | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for Medicare-covered items.* |
| 19 – Prosthetic Devices<br><br>(includes braces, artificial limbs and eyes, etc.) | 0% or 20% coinsurance | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 20% of the cost for Medicare-covered items.* |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| 20 – Diabetes Programs and Supplies | 0% or 20% coinsurance for diabetes self-management training<br><br>0% or 20% coinsurance for diabetes supplies<br><br>0% or 20% coinsurance for diabetic therapeutic shoes or inserts | *In-Network*<br>0% or 20% of the cost for Diabetes self-management training.*<br><br>0% or 20% of the cost for Diabetes monitoring supplies.*<br><br>0% or 20% of the cost for Therapeutic shoes or inserts.* |
| 21 – Diagnostic Tests, X-rays, Lab Services, and Radiology Services | 0% or 20% coinsurance for diagnostic tests and X-rays<br><br>$0 copay for Medicare-covered lab services<br><br>Lab services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.<br><br>0% or 20% coinsurance for the digital rectal exam and other related services.<br><br>Covered once a year for all men with Medicare over age 50. | *General*<br>Authorization rules may apply.<br><br>*In-Network*<br>0% or 0% to 20% of the cost for Medicare-covered lab services.*<br><br>0% or 20% of the cost for Medicare-covered diagnostic procedures and tests.*<br><br>0% or 20% of the cost for Medicare-covered X-rays.*<br><br>0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays).*<br><br>0% or 20% of the cost for Medicare-covered therapeutic radiology services.*<br><br>If the doctor provides you services in addition to Outpatient Diagnostic Procedures, Tests and Lab Services, separate cost sharing of 0% or 20% of the cost may apply.*<br><br>If the doctor provides you services in addition to Outpatient Diagnostic and Therapeutic Radiology Services, separate cost sharing of 0% or 20% of the cost may apply.* |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| **Preventive Services** | | |
| 22 – Cardiac and Pulmonary Rehabilitation Services | 0% or 20% coinsurance for Cardiac Rehabilitation services<br><br>0% or 20% coinsurance for Pulmonary Rehabilitation services<br><br>0% or 20% coinsurance for Intensive Cardiac Rehabilitation Services<br><br>This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments. | *In-Network*<br>0% or 20% of the cost for Medicare-covered Cardiac Rehabilitation Services*<br><br>0% or 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services*<br><br>0% or 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services* |
| 23 – Preventive Services and Wellness/Education Programs | No coinsurance, copayment or deductible for the following:<br><br>- Abdominal Aortic Aneurysm Screening<br>- Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.<br>- Cardiovascular Screening<br>- Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk.<br>- Colorectal Cancer Screening | *General*<br>$0 copay for all preventive services covered under Original Medicare at zero cost sharing:<br>- Abdominal Aortic Aneurysm screening<br>- Bone Mass Measurement<br>- Cardiovascular Screening<br>- Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam)<br>- Colorectal Cancer Screening<br>- Diabetes Screening<br>- Influenza Vaccine<br>- Hepatitis B Vaccine<br>- HIV Screening<br>- Breast Cancer Screening (Mammogram)<br>- Medical Nutrition Therapy Services<br>- Personalized Prevention Plan Services (Annual Wellness Visits)<br>- Pneumococcal Vaccine |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | - Diabetes Screening<br>- Influenza Vaccine<br>- Hepatitis B Vaccine for people with Medicare who are at risk<br>- HIV Screening. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.<br>- Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39.<br>- Medical Nutrition Therapy Services. Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease. | - Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only)<br>- Smoking Cessation (Counseling to stop smoking)<br>- Welcome to Medicare Physical Exam (Initial Preventive Physical Exam)<br><br>HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.<br><br>*In-Network*<br>The plan covers the following supplemental education/wellness programs:<br>- Nursing Hotline |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | - Personalized Prevention Plan Services (Annual Wellness Visits)<br>- Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.<br>- Prostate Cancer Screening – Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50.<br>- Smoking Cessation (counseling to stop smoking). 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.<br>- Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 months. | |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| 24 – Kidney Disease and Conditions | 0% or 20% coinsurance for renal dialysis<br><br>0% or 20% coinsurance for kidney disease education services | *In-Network*<br>0% or 20% of the cost for renal dialysis*<br><br>0% or 20% of the cost for kidney disease education services* |
| 25 – Outpatient Prescription Drugs | Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage. | **Drugs covered under Medicare Part B**<br><br>***General***<br>$0 annual deductible for Part B-covered drugs.*<br><br>0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.*<br><br>**Drugs covered under Medicare Part D**<br><br>***General***<br>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.caresource.com on the web.<br><br>Different out-of-pocket costs may apply for people who<br>- have limited incomes,<br>- live in long-term care facilities, or<br>- have access to Indian/Tribal/ Urban (Indian Health Service) providers.<br><br>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | | Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.<br><br>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.<br><br>Some drugs have quantity limits.<br><br>Your provider must get prior authorization from CareSource Advantage (HMO SNP) for certain drugs.<br><br>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.<br><br>If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.<br><br>If you request a formulary exception for a drug and CareSource Advantage (HMO SNP) approves the exception, you will pay Tier 3: Non-Preferred Brand Drugs cost sharing for that drug.<br><br>***In-Network***<br>You pay a $0 annual deductible. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | | ***Initial Coverage***<br>Depending on your income and institutional status, you pay the following:<br><br>For generic drugs (including brand drugs treated as generic), either:<br>- A $0 copay; or<br>- A $1.10 copay; or<br>- A $2.60 copay<br><br>For all other drugs, either:<br>- A $0 copay; or<br>- A $3.30 copay; or<br>- A $6.50 copay.<br><br>***Catastrophic Coverage***<br>After your yearly out-of-pocket drug costs reach $4,700, you pay a $0 copay.<br><br>***Out-of-Network***<br>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from CareSource Advantage (HMO SNP). |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| | | ***Out-of-Network Initial Coverage***<br>Depending on your income and institutional status, you will be reimbursed by CareSource Advantage (HMO SNP) up to the plan's cost of the drug minus the following:<br><br>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:<br>- A $0 copay; or<br>- A $1.10 copay; or<br>- A $2.60 copay<br><br>For all other drugs purchased out-of-network, either:<br>- A $0 copay; or<br>- A $3.30 copay; or<br>- A $6.50 copay.<br><br>***Out-of-Network Catastrophic Coverage***<br>After your yearly out-of-pocket drug costs reach $4,700, you will be reimbursed in full for drugs purchased out-of-network. |
| 26 – Dental Services | Preventive dental services (such as cleaning) not covered. | *In-Network*<br>0% or 20% of the cost for Medicare-covered dental benefits.*<br><br>0% of the cost of an office visit that includes:<br>- up to 1 oral exam(s) every year<br>- up to 1 cleaning(s) every year |
| 27 – Hearing Services | Supplemental routine hearing exams and hearing aids not covered.<br><br>0% or 20% coinsurance for diagnostic hearing exams. | *In-Network*<br>$0 copay for up to 1 hearing aid(s) every year.<br><br>0% or 20% of the cost for Medicare-covered diagnostic hearing exams*<br><br>$400 plan coverage limit for hearing aids every year. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| 28 – Vision Services | 0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.<br><br>Supplemental routine eye exams and glasses not covered.<br><br>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.<br><br>Annual glaucoma screenings covered for people at risk. | *In-Network*<br>0% or 20% of the cost for one pair of eyeglasses or contact lenses after cataract surgery.*<br><br>0% or 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.*<br><br>0% of the cost for up to one pair(s) of glasses every year<br><br>0% of the cost for up to 1 pair(s) of lenses every year<br><br>0% of the cost for up to 1 frame(s) every year<br><br>$125 plan coverage limit for eye wear every year. |
| Over-the-Counter Items | Not covered. | *General*<br>Please visit our plan website to see our list of covered over-the-counter items. OTC items may be purchased only for the enrollee. Please contact the plan for specific instructions for using this benefit. |
| Transportation (Routine) | Not covered. | *In-Network*<br>$0 copay for up to 30 round trip(s) to plan-approved location every year. |
| Acupuncture | Not covered. | *In-Network*<br>This plan does not cover Acupuncture. |

| Benefit Category | Original Medicare | CareSource Advantage (HMO SNP) |
|---|---|---|
| Emergency medical response system | Not covered. | *General*<br>Authorization rules apply.<br><br>*In-Network*<br>$0 copay for the emergency medical response system.<br><br>CareSource Advantage (HMO SNP) members enrolled in case management may qualify for a personal emergency medical response device/system. This benefit requires prior authorization. |

## Comprehensive Written Statement for Prospective Enrollees ODJFS Fee-For-Service Medicaid Benefits

The services listed below are available only to those SNP members eligible under **Medicaid** for medical services. Medically-necessary, Medicaid-covered services must be obtained through the Ohio Department of Job and Family Services (ODJFS), fee-for-service Medicaid Program – CareSource Advantage (HMO SNP) cannot provide Medicaid-covered services for our Medicare members.

**If you are eligible for this Special Needs Plan, you are not subject to cost sharing for Medicare Parts A and B services when the state is responsible for those amounts. Premiums, co-pays, co-insurance, and deductibles may vary based on the level of Extra Help that you may receive. If you have questions or need more information, please call Member Services.** Medicaid is usually the payer of last resort – this means, as a member of our plan, you must access benefits that are covered by both programs through Medicare (CareSource Advantage (HMO SNP) first and Medicaid (ODJFS) last. Once you have reached your limit for a service in the Medicare program, you might be able to continue getting the benefit through the Medicaid program. In some cases, Medicaid will pay for services or costs that Medicare does not (such as routine dental and vision care, and hearing aids). For SNP covered benefits, there is no Medicaid copay. However, for benefits only covered under Medicaid, copays might apply.

If you have questions about how your benefits are coordinated between programs, contact -

- Medicare-CareSource Advantage (HMO SNP) Member Services at 1-800-708-8729, Monday – Friday 8 a.m. – 8 p.m. (TTY/TDD: 1-800-750-0750 or 711).
- Medicaid-ODJFS Consumer Hotline toll-free at 1-800-324-8680 or TTY for the hearing impaired 1-800-292-3572, Monday – Friday 7a.m. – 8 p.m. and Saturday 8 a.m. – 5 p.m.

This information is a summary of the information provided in your ODJFS Medicaid Consumer Guide. For more detailed information, please refer to the most current Consumer Guide for the most up-to-date information. The services listed below are available only to those SNP members eligible under Medicaid for medical services.

## Hospital Services

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Hospital Stay<br><br>Surgery<br><br>Anesthesia | Covered as needed and when medically necessary. Some hospital services require prior authorization. Your doctor will get this before your hospital stay. | $3 copay for Medicaid non-emergency services obtained in a hospital emergency room. Otherwise, there are no member costs for Medicaid-covered services. |

## Home Health Care and Long-Term Care

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Home Health Care | Part-time health care in your home. A home health visit is less than or equal to 4 hours. Nursing, nurse aide and skilled physical, occupational, and speech therapy services must be medically necessary and ordered by your doctor after a face-to-face encounter is documented within 6 months. There are defined service limits. | $0 copay for Medicaid-covered services. |
| Long-Term Home and Community Care Options or "Waiver Services" | If you need long-term care but want to stay in your home, you may be able to do so through one of the home and community-based services waiver programs. | $0 copay for Medicaid-covered services. |
| Care in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded (ICF-MR) | These services are available to those who need long-term care in an institution. | Your Medicaid caseworker will determine a Patient Liability amount based on your income excluding certain deductions. |
| Private Duty Nursing (PDN) | Continuous nursing care in your home. A PDN visit is more than 4 hours and less than or equal to 12 hours. PDN nursing must be prior authorized by ODJFS, medically necessary and ordered by your doctor after a face-to-face encounter is | $0 copay for Medicaid-covered services. |

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|---|---|---|
| | documented within 6 months. There are defined service limits. | |
| Hospice | Hospice is end-of-life care. Hospice helps meet the needs of the patient and family during the final stages of illness and dying. Beginning in 2010 children who elect hospice may receive concurrent, curative treatment. | $0 copay for Medicaid-covered services. |

## Services at Your Health Care Provider's Office

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Doctor Office Visits | Up to 24 visits per year. You can get more if medically necessary. | $0 copay for Medicaid-covered services.<br><br>Authorization rules may apply. |
| Lab Tests, X-Rays, and Other Diagnostic Procedures | Covered when medically necessary and ordered by your doctor. | |
| Family Planning Visits and Services | As needed. | |
| Physical Exam Required for Job Placement | Exam is covered if not offered free of charge by employer. | |
| Prostate (Cancer) Tests | For men, once a year starting at age 50. | |
| Pap Smears and Pelvic Exams | Once a year for women ages 16 and older and sexually active adolescents. | |
| Mammography | For women starting at age 35-40, and then once a year thereafter. | |
| Speech Therapy | As medically necessary. | |
| Physical Therapy | Up to 30 visits each year. | |
| Occupational Therapy | Up to 30 visits each year. No limit in an outpatient hospital setting only. | |
| Chiropractic Services | Covered for adults and children. | |
| Hearing Services | Covered for adults and children. | |

## Dental, Vision, and Dermatology

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Dental Check-Ups and Cleaning | Once every 6 months for children and once every 12 months for adults. | $3 per dental visit. |
| Extractions and Fillings | As needed. | |
| Dentures and Partial Plates | Must be prior authorized. They may be replaced every 8 years. | |
| Braces | Must be prior authorized. | |
| Regular Eye Exams | If you are 21-59 years old: once every 24 months. If you are 20 years old or younger, or 60 years old or older: once every 12 months. | $2 per routine exam. |
| Eye Glasses | If you are 21-59 years old: one pair every 24 months. If you are 20 years old or younger, or 60 years old or older: one pair every 12 months. | $1 per eye glass fitting. |
| Contact Lenses, Tinted Lenses, Prosthetic Eye, and Low-Vision Aids | These items must be prior authorized and be medically necessary. | $0 copay for Medicaid-covered services. |
| Dermatology (Skin) Services | Must be medically necessary and related to a disease or condition. | $0 copay for Medicaid-covered services. |

## Prescription Medicine – Medicaid Covered Drugs

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Prescription Drugs | If you are eligible for both Medicare and Medicaid (dual eligible), your prescription drug coverage will be provided by Medicare Part D (Extra Help) prescription drug plan.<br><br>Medicaid only covers drugs that are excluded from Medicare Part D coverage such as:<br>Benzodiazepines<br>Barbiturates<br>Vitamins (except potassium, prenatal vitamins and fluoride) | $0 copay for Medicaid covered services. |

| | | |
|---|---|---|
| | Cough suppressants<br>Over-the-Counter (OTC) drugs that do not have a Medicare Part D-covered equivalent | |

## Pregnancy and Hospital Services

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Prenatal and Postpartum Doctor Visits<br>Ultrasounds<br>Childbirth Classes<br>Labor & Delivery<br>Hospital Stay<br>Health Care for Baby | Medicaid pays for all pregnancy-related services when they are needed. These services include postpartum check-ups for mom, and health care and immunizations for baby. | $0 copay for Medicaid-covered services. |

## Transportation Services

| Benefit Category | Medicaid | Member Cost |
|---|---|---|
| Transportation | If you are having a medical emergency, call 911 for an ambulance.<br><br>If you need assistance in getting to routine health care services (such as appointments with your doctor or regularly scheduled treatments) that are covered by Medicaid, contact your county department of job & family services.<br><br>If you need non-emergency transport by ambulance or wheelchair van, call the Medicaid Consumer Hotline at 1-800-324-8680 for a list of providers in your area. (Note: Medicare covers certain non-emergency trips by ambulance.) | $0 copay for Medicaid-covered services. |


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