CareSource Advantage® (HMO SNP) offered by CareSource

Annual Notice of Changes for 2014

You are currently enrolled as a member of CareSource Advantage. Next year, there will be some changes to the plan's costs and benefits*. This booklet tells about the changes.*

Additional Resources

- Member Services has free language interpreter services available for non-English speakers (phone numbers are in Section 6.1 of this booklet).
- To receive material in an alternate format or language, please call CareSource Advantage's Member Services Department at 1-800-708-8729 (TTY/TDD: 1-800-750-0750 or 711), Monday through Friday, 8 a.m. to 8 p.m.

About CareSource Advantage

- CareSource Advantage is a coordinated care plan with a Medicare Advantage contract and a contract with the Ohio Medicaid program.
- When this booklet says "we," "us," or "our," it means CareSource. When it says "plan" or "our plan," it means CareSource Advantage.

Think about Your Medicare Coverage for Next Year

Medicare allows you to change your Medicare health and drug coverage. It's important to review your coverage each fall to make sure it will meet your needs next year.

Important things to do:

- ☐ **Check the changes to our benefits and costs to see if they affect you.** Do the changes affect the services you use? It is important to review benefit and cost changes to make sure they will work for you next year. Look in Section 1 for information about benefit and cost changes for our plan.
- ☐ **Check the changes to our prescription drug coverage to see if they affect you.** Will your drugs be covered? Are they in a different tier? Can you continue to use the same pharmacies? It is important to review the changes to make sure our drug coverage will work for you next year. Look in Section 1.6 for information about changes to our drug coverage.
- ☐ **Check to see if your doctors and other providers will be in our network next year.** Are your doctors in our network? What about the hospitals or other providers you use? Look in Section 1.3 for information about our Provider Directory.
- ☐ **Think about your overall health care costs.** How much will you spend out-of-pocket for the services and prescription drugs you use regularly? How much will you spend on your premium? How do the total costs compare to other Medicare coverage options?
- ☐ **Think about whether you are happy with our plan.**

If you decide to <u>stay</u> with CareSource Advantage:	**If you decide to <u>change</u> plans:**
If you want to stay with us next year, it's easy - you don't need to do anything. If you don't make a change by December 31, you will automatically stay enrolled in our plan.	If you decide other coverage will better meet your needs, you can switch at any time. If you enroll in a new plan, your new coverage will begin on the first day of the month after you request the change. Look in Section 2.2 to learn more about your choices.

Summary of Important Costs for 2014

The table below compares the 2013 costs and 2014 costs for CareSource Advantage in several important areas. **Please note this is only a summary of changes**. **It is important to read the rest of this *Annual Notice of Changes*** and review the enclosed *Evidence of Coverage* to see if other benefit or cost changes affect you.

	2013 (this year)	2014 (next year)
Monthly plan premium* * Your premium may be higher or lower than this amount. See Section 1.1 for details.	$0	$0
Yearly deductible	Part A Deductible: $1,184 Part B Deductible: $147	Part A Deductible: $1,184 Part B Deductible: $147 These were the 2013 amounts. These amounts may change for 2014.
Doctor office visits	Primary care visits: $0 per visit Specialist visits*:* 20% after deductible per visit	Primary care visits: $0 per visit Specialist visits: 20% after deductible per visit
In-patient hospital stays	Deductible: $1,184 per benefit period (day 0-60). Beyond the first 60 days, day 61-90 = $296 co-pay per day, day 91-150 = $592 co-pay per day	Deductible: $1,184 per benefit period (day 0-60). Beyond the first 60 days, day 61-90 = $296 co-pay per day, day 91-150 = $592 co-pay per day These were the 2013 amounts. These amounts may change for 2014.

Part D prescription drug coverage (See Section 1.6 for details.)	Deductible: $0, $66 Co-pays during the Initial Coverage Stage: • Drug Tier 1: $0.00, $1.15, $2.65, $3.50, $6.60, 15% • Drug Tier 2: $0.00, $1.15, $2.65, $3.50, $6.60, 15% • Drug Tier 3: $0.00, $1.15, $2.65, $3.50, $6.60, 15% • Drug Tier 4: $0.00, $1.15, $2.65, $3.50, $6.60, 15%	Deductible: $0, $63 Copays during the Initial Coverage Stage: • Drug Tier 1: $0.00, $1.20, $2.55, $3.60, $6.35, 15% • Drug Tier 2: $0.00, $1.20, $2.55, $3.60, $6.35, 15%. • Drug Tier 3: $0.00, $1.20, $2.55, $3.60, $6.35, 15% • Drug Tier 4: $0.00, $1.20, $2.55, $3.60, $6.35, 15%
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$6,700	$6,700

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SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

	2013 (this year)	2014 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium unless it is paid for you by Medicaid.)	$0	$0

- Your monthly plan premium will be *more* if you are required to pay a late enrollment penalty.
- If you have a higher income as reported on your last tax return ($85,000 or more), you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.
- Your monthly premium will be *less* if you are receiving "Extra Help" with your prescription drug costs.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

To protect you, Medicare requires all health plans to limit how much you pay "out-of-pocket" during the year. This limit is called the "maximum out-of-pocket amount." Once you reach the maximum out-of-pocket amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

	2013 (this year)	2014 (next year)
Maximum out-of-pocket amount Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. Your costs for covered medical services (such as copays and	$6,700	$6,700 Once you have paid $6,700 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for

	2013 (this year)	2014 (next year)
deductibles) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.		the rest of the calendar year.

Section 1.3 – Changes to the Provider Network

There are changes to our network of doctors and other providers for next year. We included a copy of our Provider Directory in the envelope with this booklet. You may also call Member Services for updated provider information or to ask us to mail you a Provider Directory. **Please review the 2014 Provider Directory to see if your providers are in our network**.

Section 1.4 – Changes to the Pharmacy Network

Amounts you pay for your prescription drugs may depend on which pharmacy you use. Medicare drug plans have a network of pharmacies. In most cases, your prescriptions are covered *only* if they are filled at one of our network pharmacies.

There are changes to our network of pharmacies for next year. We included a copy of our Pharmacy Directory in the envelope with this booklet. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2014 Pharmacy Directory to see which pharmacies are in our network**.

Section 1.5 – Changes to Benefits and Costs for Medical Services

We are changing our coverage for certain medical services next year. The information below describes these changes. For details about the coverage and costs for these services, see Chapter 4, Benefits Chart (what is covered and what you pay), in your 2014 Evidence of Coverage. We will send you the Evidence of Coverage by December 31.

	2013 (this year)	2014 (next year)
Outpatient Mental Health care	You pay 0% or 35% of the cost for each Medicare-covered	You pay 0% or 20% of the cost for each Medicare-covered

	individual therapy visit.	individual therapy visit.
	You pay 0% or 35% of the cost for each Medicare-covered group therapy visit.	You pay 0% or 20% of the cost for each Medicare-covered group therapy visit.
	You pay 0% or 35% of the cost for each Medicare-covered individual therapy visit with a psychiatrist.	You pay 0% or 20% of the cost for each Medicare-covered individual therapy visit with a psychiatrist.
	You pay 0% or 35% of the cost for each Medicare-covered group therapy visit with a psychiatrist.	You pay 0% or 20% of the cost for each Medicare-covered group therapy visit with a psychiatrist.

Section 1.6 – Changes to Part D Prescription Drug Coverage

Changes to Mail-Order Services

Our plan allows members to use an "automatic refill" service for their mail-order drugs. If you used our "automatic refill" service in the past, we automatically sent you a refill of your drugs when our records indicated that you were about to run out. Starting in January 2014, to be sure you only get drugs you really need, we will need to get your permission before we can send you a refill by mail.

Changes to Our Drug List

Our list of covered drugs is called a Formulary or "Drug List." A copy of our Drug List is in this envelope.

We made changes to our Drug List, including changes to the drugs we cover and changes to the restrictions that apply to our coverage for certain drugs. **Review the Drug List to make sure your drugs will be covered next year and to see if there will be any restrictions.** The Drug List we included in this envelope includes many – *but not all* – of the drugs that we will cover next year. If you don't see your drug on this list, it might still be covered. **You can get the *complete* Drug List** by calling Member Services (see the back cover) or visiting our website (CareSource.com).

If you are affected by a change in drug coverage you can:

- **Work with your doctor (or other prescriber) and ask the plan to make an exception** to cover the drug. **Current members** can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, you'll be able to get your drug at the start of the new plan year.
    - To learn what you must do to ask for an exception, see Chapter 9 of your *Evidence of Coverage* (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* or call Member Services.
- **Find a different drug** that we cover. You can call Member Services to ask for a list of covered drugs that treat the same medical condition.

In some situations, we will cover a **one-time**, temporary supply. (To learn more about when you can get a temporary supply and how to ask for one, see Chapter 5, Section 5.2 of the *Evidence of Coverage.*) During the time when you are getting a temporary supply of a drug, you should talk with your doctor to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. If you are a current member affected by a formulary change from one year to the next, we will provide you with the opportunity to request a formulary exception in advance for the following year.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you get "Extra Help" and didn't receive this insert with this packet, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are in Section 6.1 of this booklet.

There are four "drug payment stages." How much you pay for a Part D drug depends on which drug payment stage you are in. (You can look in Chapter 6, Section 2 of your *Evidence of Coverage* for more information about the stages.)

The information below shows the changes for next year to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage. To get information about your costs in these stages, look in your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in the *Evidence of Coverage*.)

In addition to the changes in costs described below, there is a change to daily cost sharing that might affect your costs in the Initial Coverage Stage. Starting in 2014, when your doctor first prescribes less than a full month's supply of certain drugs, you may no

longer need to pay the copay for a full month. (For more information about daily cost sharing, look at Chapter 6, Section 5.3, in the *Evidence of Coverage*.)

Changes to the Deductible Stage

	2013 (this year)	2014 (next year)
Stage 1: Yearly Deductible Stage During this stage, you pay the full cost of your Preferred Brand, Non Preferred Brand, and Specialty Tier drugs until you have reached the yearly deductible.	The deductible is $0, $66. Your deductible amount is either $0 or $66, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.) ..	The deductible is $0, $63 Your deductible amount is either $0 or $63, depending on the level of “Extra Help” you receive. (Look at the separate insert, the “LIS Rider,” for your deductible amount.)

Changes to Your Copayments in the Initial Coverage Stage

	2013 (this year)	2014 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your *Evidence of Coverage*. We changed the tier for some of the drugs on our Drug List. To see if your drugs will be in a different tier, look them up on the Drug List.	Your cost for a one-month supply filled at a network pharmacy: **Preferred brand and generic drugs:** You pay $0.00, $1.15, $2.65, $3.50, $6.60 per prescription OR 15 % of the total cost. **Preferred brand and non-preferred generic drugs:** You pay $0.00, $1.15, $2.65, $3.50, $6.60 per prescription OR 15% of the total cost. **Non-preferred brand and non-preferred generic drugs**: You pay $0.00, $1.15, $2.65, $3.50, $6.60 per prescription OR 15% of the total cost. **Specialty brand and generic drugs**: You pay $0.00, $1.15, $2.65, $3.50, $6.60 per prescription OR 15% of the total cost _____ Once your total drugs costs have reached $2,970, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy: **Generic drugs:** You pay $0.00, $1.20, $2.55, $3.60, $6.35 per prescription OR 15 % of the total cost. **Preferred brand drugs:** You pay $0.00, $1.20, $2.55, $3.60, $6.35 per prescription OR 15% of the total cost. **Non-preferred brand dugs:** You pay $0.00, $1.20, $2.55, $3.60, $6.35 per prescription OR 15% of the total cost. **Specialty brand and generic drugs**: You pay $0.00, $1.20, $2.55, $3.60, $6.35 per prescription OR 15% of the total cost. _____ Once your total drugs costs have reached $2,850, you will move to the next stage (the Coverage Gap Stage).

There is another important change that might affect your costs in the Initial Coverage Stage. Generally, your copay has been the same whether you filled your prescription for a full month's supply or for fewer days. However, starting in 2014, your copay for some drugs will be based on the actual number of days' supply you receive rather than a set amount for a month. There may be times when you want to ask your doctor about prescribing less than a full month's supply of a drug (for example, when your doctor first prescribes a drug that is known to cause side effects). If your doctor prescribes less than a full month's supply of certain drugs, and you are required to pay a copay, you will no longer have to pay for a month's supply. Instead, you will pay a lower copay (a daily cost-sharing rate) based on the number of days of the drug that you receive.

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**. For information about your costs in these stages, look at your *Summary of Benefits* or at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Deciding Which Plan to Choose

Section 2.1 – If you want to stay in CareSource Advantage

To stay in our plan you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 31, you will automatically stay enrolled as a member of our plan for 2014.

Section 2.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change for 2014 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- -- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan and whether to buy a Medicare supplement (Medigap) policy.

To learn more about Original Medicare and the different types of Medicare plans, read *Medicare & You 2014*, call your State Health Insurance Assistance Program (see Section 4), or call Medicare (see Section 6.2).

You can also find information about plans in your area by using the Medicare Plan Finder on the Medicare website. Go to http://www.medicare.gov and click "Compare Drug and Health Plans." **Here, you can find information about costs, coverage, and quality ratings for Medicare plans.**

Step 2: Change your coverage

- To change **to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from CareSource Advantage.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from CareSource Advantage.
- To **change to Original Medicare without a prescription drug plan,** you must either:
    - Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are in Section 6.1 of this booklet).
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 3 Deadline for Changing Plans

You can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 4 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Ohio, the SHIP is called the Ohio Senior Health Insurance Information Program (OSHIIP).

OSHIIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give **free** local health insurance counseling to people with Medicare. OSHIIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call OSHIIP at 1-800-686-1578. You can learn more about OSHIIP by visiting their website (www.insurance.ohio.gov/Consumer/Pages/ConsumerTab2.aspx).

SECTION 5 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs.

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to seventy-five (75) percent or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office.

SECTION 6 Questions?

Section 6.1 – Getting Help from CareSource Advantage

Questions? We're here to help. Please call Member Services at 1-800-708-8729 (TTY only, call 1-800-750-0750 or 711). We are available for phone calls Monday through Friday from 8 a.m. to 8 p.m. Calls to these numbers are free.

Read your 2014 *Evidence of Coverage* (it has details about next year's benefits and costs)

This *Annual Notice of Changes* gives you a summary of changes in your benefits and costs for 2014. For details, look in the 2014 *Evidence of Coverage* for CareSource Advantage. The *Evidence of Coverage* is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. We will send you a copy of the *Evidence of Coverage* by December 31.

Visit our website

You can also visit our website at CareSource.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

Section 6.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare website

You can visit the Medicare website (http://www.medicare.gov). It has information about cost, coverage, and quality ratings to help you compare Medicare health plans. You can find information about plans available in your area by using the Medicare Plan Finder on the Medicare website. (To view the information about plans, go to http://www.medicare.gov and click on “Compare Drug and Health Plans.”)

Read Medicare & You 2014

You can read *Medicare & You 2014* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don’t have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6.3 – Getting Help from Medicaid

To get information from Medicaid, you can call the Ohio Office of Medical Assistance (OMA) at 1-800-324-8680. TTY users should call 1-800-292-3572.