Health Insurance Marketplace

All NC health plans offered by CareSource North Carolina Co. d/b/a CareSource

Our Mission

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

ABOUT US

- A nonprofit health care plan and national leader in Managed Care
- 30+ year history of serving varied populations across multiple states and insurance products
- Currently serving over 2.32 million members* in Arkansas, Georgia, Indiana, Kentucky, Michigan, North Carolina, Ohio and West Virginia
- 4,500 employees located across 30 states

2M+

members

*Based on members enrolled in all CareSource product lines across all states as of 7/23/2024.

CARESOURCE

OUR VISION

Transforming lives through
innovative health and life services.

It’s not just about making a change.
It’s about making a difference.

We got you.

Qualified health plans and ACA compliant.

All essential health benefits covered.

Coverage for pre-existing conditions.

No annual or lifetime dollar limits for essential health benefits.

Preventive services covered at no cost.

Saving Money On Health Insurance

The majority of CareSource Marketplace members may qualify for subsidies* that help bring down the total cost of a Marketplace insurance plan.

COST-SHARING REDUCTION (CSR)

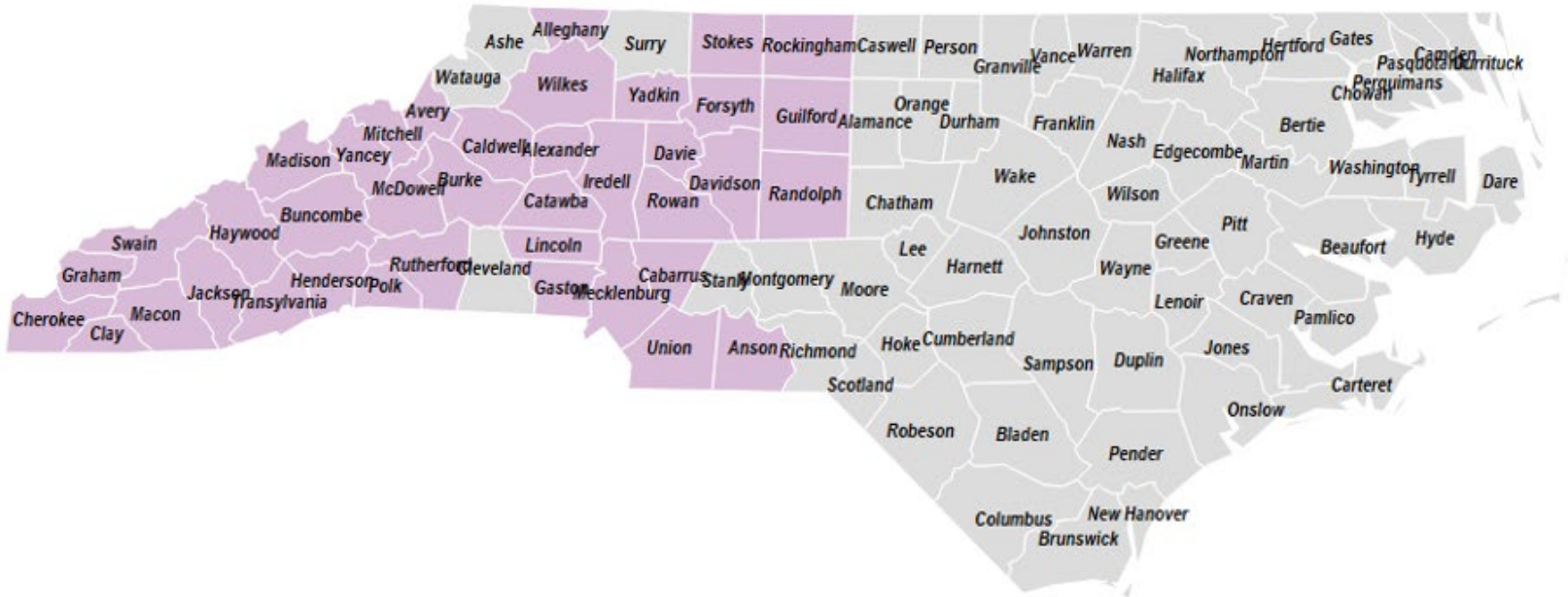
Extra savings on out-of-pocket costs that lower the amount owed for any deductible, copayments and coinsurance. CSRs only apply to Silver plans#, so if you qualify for a CSR, you must enroll in a Silver plan through the exchange to get it.

ADVANCE PREMIUM TAX CREDIT (APTC)

Tax credit taken in advance, in whole or in part, to lower monthly premium payments. If you qualify, this can be used no matter which metal level plan (Gold, Silver, Bronze) you enroll in.

*Based on CareSource Marketplace membership as of June 2024. Eligibility for subsidies is determined by the Health Insurance Marketplace, not CareSource.
#CSRs are also applicable on Limited and Zero plans, available only to members of federally-recognized tribes and ANCSA corporation shareholders.

CareSource Coverage Area



Call: 1-844-539-1733 (TTY: 711)

CareSource.com/Plans/Marketplace

*Coverage area subject to change.

Consider This…

It is easy to underestimate how much medical care can cost:

- A broken leg can cost up to $7,500 to treat.
- The average cost of a three-day hospital stay is around $30,000.
- Comprehensive cancer care can cost hundreds of thousands of dollars.

Having health coverage can help protect you from high, unexpected costs like these.

Source: healthcare.gov/why-coverage-is-important/protection-from-high-medical-costs/

Essential Health Benefits

- Preventive and wellness services and chronic disease management
- Emergency services
- Hospitalization
- Prescription drugs
- Pediatric services, including vision care
- Pregnancy, maternity and newborn care
- Ambulatory patient services
- Mental health and substance use disorder services
- Rehabilitative and habilitative services and devices
- Laboratory services

Open Enrollment

November 1 – January 15

New enrollees must make their first premium payment to activate their coverage.

How to Enroll:

- Call your local insurance agent or agency.
- Visit: Enroll.CareSource.com
- Call: 1-844-539-1733 (TTY: 711)

After January 15, you can only enroll if you have a qualifying life event for a Health Insurance Marketplace “Special Enrollment Period” (SEP).

If you enroll after December 15, be aware that your enrollment will not take effect on January 1, 2025.

Special Enrollment Period

Examples of the most common qualifying life events include:

1. Getting married
2. Having a baby
3. Moving outside your insurer’s coverage area
4. Getting a divorce
5. Leaving incarceration
6. Adopting a child or placing a child for adoption or foster care
7. Losing minimum essential coverage

Available year-round for people who qualify.

Federal and state laws limit enrollment into CareSource plans to designated time periods within a calendar year (open enrollment), unless you qualify for a special enrollment period. CareSource does not determine whether you will qualify for a special enrollment period. Please contact the Health Insurance Marketplace for greater detail on special enrollment periods.

Bronze Plans

Lowest Premiums, Highest Out-of-Pocket Costs

Our Bronze First plan offers access to key services - such as primary care and some prescription drugs - prior to having to satisfy your deductible.

	Bronze First 7500 $25 Generic Drugs
Deductible	$7,500
Out-of-Pocket Maximum	$9,200
Coinsurance	50%
Primary Care or Retail Clinic Visit	$50
Specialist Visit	$100
Urgent Care Visit	$75
Emergency Room Visit	50%*
Generic Prescription Drug Coverage (30-Day Retail/90-Day Retail/90-day Mail) ‡	$25 $75 $75
^Pediatric Vision Services	$0 for the first exam, $0 retinal imaging, $0 for first pair of glasses/contacts, multiple lens options – many at no member cost, low vision testing and aides, additional discounts on other services and glasses.

*After deductible. ‡Applicable only to drugs in the generic tier 1 on the formulary. These copays are the max you may pay for tier 1 drugs. Some drugs may cost less than your copay. In the chart above, amounts using a dollar sign ($) refer to copays (except for deductible, out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance.
^CareSource has partnered with EyeMed®.

Silver Plans

Budget-Friendly, Subsidy-Eligible

NEW for 2025: Healthy Heart Silver for all markets!

Choose the plan that fits your budget - Low Premium, Diabetes Silver, Healthy Heart Silver, HDHP Preventive Silver or the Standard plan which helps you balance premiums and cost shares (deductibles, copays and coinsurance). Plus, Silver plans are subsidy-eligible (Cost Share Reduction) for those who qualify.

	†Low Premium Silver 6000 $3 Generic Drugs	†Silver 5000 $20 Generic Drugs	†Diabetes Silver 4000 $0 Select Drugs & Specialized Services	†Healthy Heart Silver 4500 $0 Select Drugs & Specialized Services	†HDHP Preventive Silver 5500 $0 Select Drugs
Deductible	$6,000	$5,000	$4,000	$4,500	$5,500
Out-of-Pocket Maximum	$9,000	$8,000	$8,800	$8,800	$5,500
Coinsurance	40%	40%	50%	50%	0%
Primary Care or Retail Clinic Visit	$35	$40	$30	$30	$0*
Specialist Visit	$75	$80	$50	$50	$0*
Urgent Care Visit	$70	$60	$70	$70	$0*
Emergency Room Visit	$500*	40%*	$600*	50%*	$0*
Generic Prescription Drug Coverage (30-day Retail/90-day Retail/90-day Mail) ‡	$3 $9 $9	$20 $60 $60	$3 $9 $9	$3 $9 $9	$0*
^Pediatric Vision Services	$0 for the first exam, $0 retinal imaging, $0 for first pair of glasses/contacts, multiple lens options – many at no member cost, low vision testing and aides, additional discounts on other services and glasses.				

*After deductible. †Silver 1, 2 and 3 are based upon eligibility for Cost Sharing Reductions (CSR) as determined by the Exchange. ‡Applicable only to drugs in the generic tier 1 on the formulary. These copays are the max you may pay for tier 1 drugs. Some drugs may cost less than your copay. In the chart above, amounts using a dollar sign ($) refer to copays (except for deductible, out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance. ^CareSource has partnered with EyeMed®.

Gold Plan

Higher Premiums, Lower Out-of-Pocket Costs
NEW for 2025: Healthy Heart Gold for all markets!

Typically, a good choice if you expect to have a lot of doctor appointments, need many prescription medicines or need other health services. Gold plans also have chronic condition plan options that offer special preferred coverage for medications, supplies and care.

	Gold 1500 $15 Generic Drugs	Core Gold 1500 $10 Generic Drugs	Diabetes Gold 1100 $0 Select Drugs & Specialized Services	Healthy Heart Gold 1500 $0 Select Drugs & Specialized Services
Deductible	$1,500	$1,500	$1,100	$1,500
Out-of-Pocket Maximum	$7,800	$7,000	$7,500	$7,500
Coinsurance	25%	25%	30%	30%
Primary Care or Retail Clinic Visit	$30	$20	$10	$10
Specialist Visit	$60	$60	$40	$40
Urgent Care Visit	$45	$40	$30	$30
Emergency Room Visit	25%*	$400*	$500*	$0*
Generic Prescription Drug Coverage (30-day Retail/ 90-day Retail/90-day Mail) ‡	$15 $45 $45	$10 $30 $30	$2 $6 $6	$2 $6 $6
^Pediatric Vision Services	$0 for the first exam, $0 retinal imaging, $0 for first pair of glasses/contacts, multiple lens options – many at no member cost, low vision testing and aides, additional discounts on other services and glasses.			

*After deductible. ‡Applicable only to drugs in the generic tier 1 on the formulary. These copays are the max you may pay for tier 1 drugs. Some drugs may cost less than your copay. In the chart above, amounts using a dollar sign ($) refer to copays (except for deductible, out-of-Pocket Maximum). Amounts using a percentage (%) refer to coinsurance. ^CareSource has partnered with EyeMed®.

Featured Plans & Benefits for 2025!

CareSource®

Diabetes Silver & Diabetes Gold

While anyone can enroll in these plans, they are designed to reduce expenses for diabetic-related services, drugs and drug supplies.

$0 Screenings and Tests:

- A1C testing
- Retinopathy eye screening
- Diabetic kidney disease screening
- Routine diabetic foot care
- Diabetes self-management education
- Nutritional counseling

$0 Drugs*:

- Regular insulins – Humulin® N, Novolin® N, Humulin® R, Novolin® R, Humulin® 70-30, Novolin® 70-30
- Rapid-acting insulins – Humalog®, insulin lispro, insulin aspart
- Long-acting insulins – Basaglar®, Rezvoglar ™ and Tresiba®
- Generic oral drugs – Acarbose, alogliptin, alogliptin-metformin, alogliptin-pioglitazone, glimepiride, glipizide, glipizide-metformin, glyburide, glyburide-metformin, metformin, miglitol, nateglinide, pioglitazone, pioglitazone-metformin, pioglitazone-glimepiride, repaglinide
- Brand name oral drugs – Jardiance®*, Farxiga®*, Januvia®* and Janumet®*

$0 Self-Management Supplies on Prescription Drug List *:

- Glucose meter and test strips (OneTouch Verio®)
- Continuous glucose monitor (Dexcom, Freestyle Libre)
- Pen needles, insulin syringes, lancing devices/lances, alcohol swabs, urine ketone test strips

^Rider Benefits:

- Adult routine vision – eye exams

*Prior authorization or step therapy required.
^Service Area Restrictions Apply.

Healthy Heart Silver & Healthy Heart Gold

While anyone can enroll in these plans, they are designed to reduce expenses for heart related services, drugs and supplies.

$0 Tests and Screenings:

- Lipid panel
- Prothrombin test
- Metabolic panel
- EKG

$0 Drugs:

- Generic drugs - Amiodarone, Digoxin, Flecainide, Sotalol, Sotalol AF
- Brand name drugs – Jardiance®*, Farxiga®*, Entresto™*

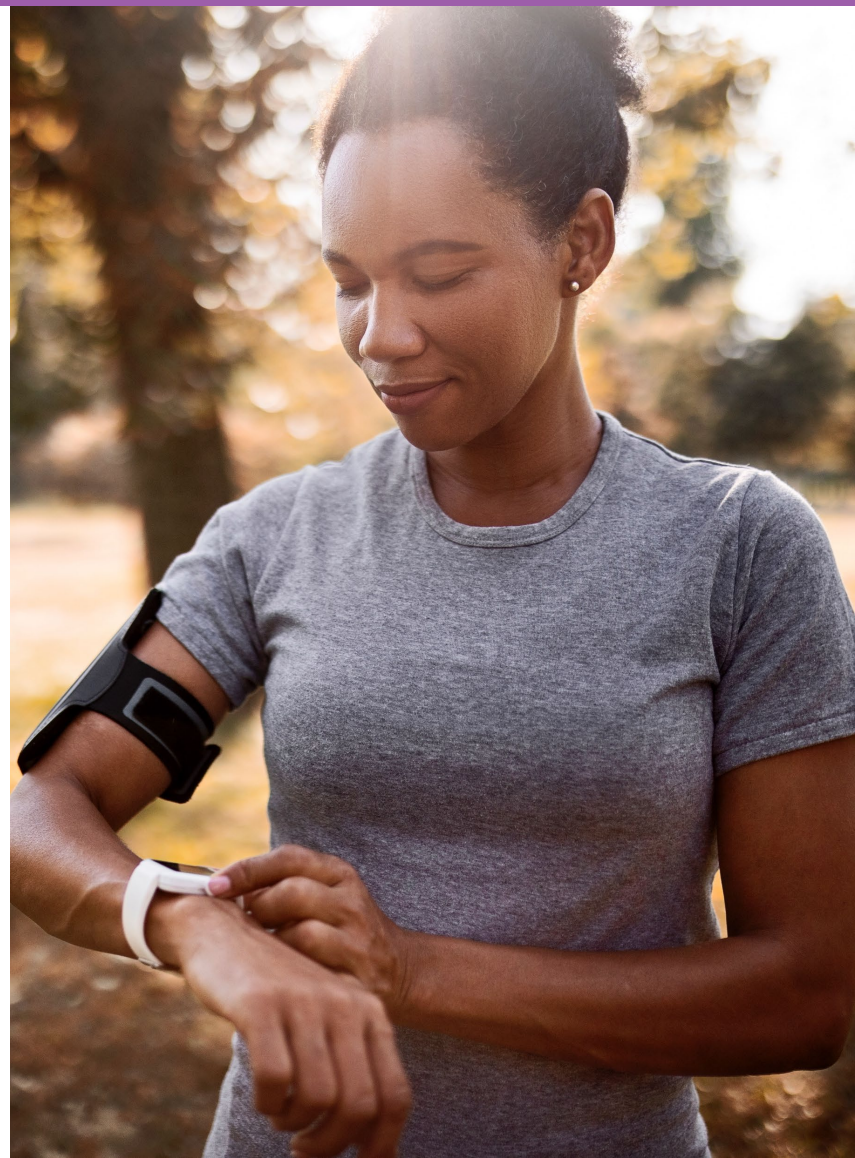
$0 Durable Medical Equipment:

- Blood pressure cuff (limit of one per eligible member)
- Gradient compression stockings

^Rider Benefits:

- Adult routine vision – eye exams

*Prior authorization or step therapy required. ^Service Area Restrictions Apply.



HDHP Preventive Silver & Preventive Silver

While anyone can enroll in this plan, it's designed to reduce expenses on preventive care for those diagnosed with chronic conditions such as diabetes, congestive heart failure and coronary artery disease.

HDHP Preventive Silver is HSA eligible!

$0 Tests and Screenings:

- Retinopathy eye screening
- Hemoglobin A1C Test
- Low density lipoprotein (LDL)

$0 Preventive Drugs:

- ACE inhibitors – Benazepril, captopril, enalapril, fosinopril, lisinopril, quinapril, ramipril, trandolapril, benzapril-hctz, captopril-hctz, enalapril-hctz, fosinapril-hctz, lisinopril-hctz, quinapril-hctz
- Beta-blockers – Acebutolol, atenolol, bisoprolol, metoprolol succinate (ER), metoprolol tartrate (IR), nadolol, propranolol, sotalol, sotalol AF, timolol
- Statins – Atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin

Anti-diabetics*:

- Generics: Acarbose, alogliptin, alogliptin-metformin, alogliptin-pioglitazone, glimepiride, glipizide, glipizide-metformin, glyburide, glyburide-metformin, metformin, miglitol, nateglinide, pioglitazone, pioglitazone-metformin, pioglitazone-glimepiride, repaglinide
- Brand name: Farxiga®*, Jardiance®*, Synjardy®*, Januvia®*, Janumet®*
- Insulins: Basaglar®, Rezvoglar™, Tresiba®, Humalog®, Humulin® N, Humulin® R, Humulin® 70-30, insulin aspart, insulin lispro, Novolin® N, Novolin® R, Novolin® 70-30

$0 Self-Management Supplies on Prescription Drug List:

- Diabetic Supplies: Alcohol swabs, glucose meter and test strips (OneTouch Verio®), lancets/lancing device, pen needles, insulin syringes/needles, urine ketone test strips

*Prior authorization or step therapy required.

Rewards & Incentives

CareSource®

Optional Adult Vision and Fitness Benefits

For around $4* more per month, adults on your plan get access to benefits to treat the whole person – vision and fitness – all within a singular premium and relationship.

*Based on a single 30-year-old member. Your premium difference may be more or less based on your member and plan characteristics.

Adult Vision Benefits

CareSource partnered with EyeMed® to bring you access to the biggest network with the most choice – including hundreds of independent providers, and truly in-network access to popular national retailers as well as regional favorites. There are convenient locations with extended evening and weekend hours.

Vision Care Services	In-Network Member Cost
Exam with Dilation as Necessary	$0-$65 copay or 40% coinsurance.† Retinal imaging at no cost to member.
Frame, Lenses and Options Package Any frame, lenses and lens options available at provider location.	$250 allowance for frame, lenses and lens options, 20% off balance over $250.
Contact Lenses (includes materials only for one of the options below)	
Conventional	$0 copay; $250 allowance, 15% off balance over $250.
Disposable	$0 copay; $250 allowance, plus balance over $250.
Laser Vision Correction LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price.
Frequency Examination Frame and lenses or contact lenses	 Once every calendar year. Once every calendar year.

†Extra discounts may be available for those that qualify for a CSR.

Additional savings...

40% off additional pair discount*

20% off non-prescription sunglasses*

20% off any remaining frame balance*

*These discounts are offered at in-network providers only. Discounts are not funded by CareSource.

Fitness Benefits

The Adult Vision and Fitness plan comes with all these fitness benefits. No monthly gym fee, no contracts, no cost*!

- **Fitness Center Membership:** Join participating fitness centers in our robust national network of 13,000+ locations*, including select LA Fitness®, Planet Fitness® and more. Access the premium fitness network, with a buy-up price, with 7,000+ fitness center and studio choices, and unique experiences like rock climbing gyms and rowing centers.
- **Home Fitness Kits:** Get one home fitness kit. Choose from yoga, Pilates, total body strength and more. Some kits include a wearable device (e.g., Fitbit® or Garmin®).
- **On-Demand Workout Videos:** 8,000+ selections, for all fitness levels.
- **Healthy Living Coaching:** Over-the-phone coaching in areas like as fitness, nutrition, stress and sleep.
- Quarterly newsletter, Get Started Program, and other online tools and education at www.ActiveandFit.com.

*Limitations and Exclusions apply to the Program. Full details are available in the applicable 2025 CareSource Marketplace plan Evidence of Coverage or by calling CareSource. Non-standard services at the fitness center and premium fitness network may have costs associated.

How To Enroll

Visit Enroll.CareSource.com
Shop for plans, compare benefits, premiums and cost-sharing amounts. Then, enroll in the plan that suits your health care needs and budget best!

Prefer to talk to someone?
Call your local insurance agent. If you don't have one, our staff is here and happy to help you!
Just call toll-free
1-844-539-1733 (TTY: 711)

Other Ways to Enroll:

- Visit **HealthCare.gov** or contact the Marketplace at **1-800-318-2596**.

Open enrollment begins on November 1.

Broker Services Best Practices

- **Ready to Sell:** If you are newly onboarding, you are considered “Ready To Sell” when you have received a Welcome Letter.

- **Training Requirements:**
  - To sell Marketplace, you must have a 2025 FFM Certificate.
  - To sell Marketplace in Kentucky, you must also complete Kentucky’s training via Kynect.
    Note: If you are only selling Marketplace in Kentucky, only Kentucky’s training is required and the FFM is not needed.
  - To sell Marketplace in Georgia, you must also complete Georgia’s training via Georgia Access.
    Note: If you are only selling Marketplace in Georgia, only Georgia’s training is required and the FFM is not needed.
  - To sell Medicare, you must pass a comprehensive background investigation, have your 2025 AHIP certificate and successfully complete our 2025 Medicare product specific training.

- **State Appointment(s):** An approved state appointment is required before you make a sale.
  - CareSource honors state appointment guidelines and while some states allow either a 15- or 30-day window to become appointed, CareSource requires you to be appointed before the sale.
    - Important note: Sales made before you are fully credentialed (licensed, appointed where applicable and certified) will not pay commission.
- **Hierarchy move:** Hierarchy moves are honored from January 1 – August 31. Please consult your upline for details.

Compliance Requirements - Medicare

Alignment of Part C and Part D Special Enrollment Periods with Medicare Exceptional Condition Enrollment. CMS has added “exceptional condition” SEPs for enrollment into Medicare Parts A and B, thus corresponding SEPs are finalized for MA enrollment. The SEP begins when the individual submits their application for premium Part A and Part B, or Part B only, if the individual is already entitled to Part A (or is enrolling in premium-free Part A within the timeframe for use of this SEP), and continues for the first two (2) months beyond the premium Part A and/or Part B entitlement date. The MA enrollment is effective the first of the following month following the month the MA plan receives the enrollment.

Expanding eligibility for Low-Income Subsidies (LIS) under Part D. To be eligible for the full subsidy for plan years beginning on or after January 1, 2024, an individual must have an income below 150 percent of the Federal Poverty Level (FPL). 150 percent is the current level for the partial subsidy, so this effectively sunsets the partial subsidy income requirements after 2023.

Modify the required disclaimer to add State Health Insurance Programs (SHIPs) as a source of information for beneficiaries.
If an agent or organization does not sell for all MA Organizations and/or Part D sponsors in the service area, an additional disclaimer is required: list names of the MA organizations or Part D sponsors with which they contract in the applicable service area.

> "We do not offer every plan available in your area. Currently we represent **[***insert number of organizations***]** organizations which offer **[***insert number of plans***]** products in your area. Please contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program to get information on all of our options"

If an agent or organization does sell for all MA organizations and/or Part D sponsors in the service area a separate disclaimer must indicate they do offer all plans in the service area.

> "Currently we represent **[***insert number of organizations***]** organizations which offer **[***insert number of plans***]** products in your area. You can always contact Medicare.gov, 1-800-MEDICARE, or your local State Health Insurance Program for help with plan choices."

Compliance Requirements – Medicare continued

Possible End Dates for the SEP for Government Entity-Declared Disaster or Other Emergency (§§ 422.62 and 423.38)
1. This provision updates the SEP rules for individuals affected by an emergency or major disaster declared by a Federal, State or local government entity.
2. The SEP ends 2 full calendar months following the end date identified in the declaration or, if different, the date the end of the incident is announced or the date the incident automatically ends under applicable state or local law.
3. If the incident end date of an emergency or major disaster is not otherwise identified, the incident end date is 1 year after the SEP start date; or, if applicable, the date of a renewal or extension of the emergency or disaster declaration, whichever is later. The maximum length of this SEP, if the incident end date is not otherwise identified, is 14 full calendar months after the SEP start date or, if applicable, the date of a renewal or extension of the emergency or disaster declaration.

Updating MA and Part D SEPs for Changes in Residence and Codifying Procedures for Developing Addresses for Members Whose Mail is Returned as Undeliverable (§§ 422.62, 422.74, 423.38 and 423.44)
1.Codification of longstanding guidance to specify a SEP for individuals who move within the service area of their current plan and have new Medicare health or drug plan options available to them, as well as to those who are not currently enrolled in a Medicare health or drug plan who move and have new plan options available to them.
2.Also codifies that an individual is considered to be temporarily absent from the plan service area when any one or more of the required materials and content referenced in §§ 422.2267(e) and 423.2267(e), if provided by mail, is returned to the plan sponsor by the US Postal Service as undeliverable and a forwarding address is not provided.

Revise Initial Coverage Election Period Timeframe To Coordinate With A/B Enrollment (§ 422.62)
CMS finalized the extension of the timeframe for an individual to elect MA when first eligible. Specifically, the rule allows an individual who newly enrolls in Part A and/or Part B beyond their initial Medicare enrollment period to elect to join an MA plan up to two (2) months after the date they have both Part A and Part B coverage. Currently, a person who does not elect MA before the effective date of their Part A and B coverage generally must wait until the next enrollment period that is available to them to make an MA election.

Authorized Representatives for Parts C/D Elections (§§ 422.60 and 423.32)
CMS codified existing manual guidance on an authorized representative making an MA election on behalf of a beneficiary or enrollee. Specifies that an authorized representative is one with state-issued legal authority to act and make health care decisions on behalf of the beneficiary. The rule adds new paragraphs §§ 422.60(i) and 423.32(j).

Beneficiary Choice of C/D Effective Date if Eligible for More Than One Election Period (§§ 422.68 and 423.40)
Sales agents understand and are able to select an applicable SEP at the time of enrollment. Beneficiaries are able to choose the election period that results in the desired effective date. If the beneficiary does not make a choice, CMS provides (in existing sub-regulatory guidance) a ranking of different enrollment windows for determining effective date. This finalizes new paragraphs §§ 422.68(g) and 423.40(f).

Compliance Requirements - Medicare continued

Distribution of Personal Beneficiary Data by Third Party Marketing Organizations (§§ 422.2274(g) and 423.2274(g))

1. TPMOs are only permitted to share personal beneficiary data with other TPMOs for marketing or enrollment purposes ONLY if they first obtain EXPRESS written consent from the relevant beneficiary. Effective October 1, 2024: This includes beneficiary data that is collected prior to October 1, 2024, but will be transferred or shared with another TPMO on or after October 1, 2024. Therefore, TPMOs must have prior express written consent to share a beneficiary's personal data on or after October 1, 2024.
    a. This new rule will require lead generators and comparison-shopping websites to obtain one-to-one consent with a clear and conspicuous disclosure from the consumer for each seller that intends to make a call or send a text using an automatic telephone dialing system or make a call containing an artificial/prerecorded voice.
        i. Therefore, even if a lead generator or comparison-shopping website lists multiple sellers on its webpage, each seller is responsible for obtaining the prior express written consent from the called party through a "clear and conspicuous" disclosure on the lead generator or comparison-shopping website in order to robocall or robotext the consumer.
    b. Example:
        i. When a live call can be transferred to another entity for assistance it is an acceptable approach that can be accomplished without obtaining prior express written consent as long as the beneficiary has verbally agreed or consented to be transferred during the live phone call. But, if the TPMO will need to share beneficiary personal data with anyone that they will not be speaking with immediately they will need to get prior express written consent to share personal data.
2. If a TPMO collects a beneficiary's personal beneficiary data with the purpose of eventually marketing or enrolling that beneficiary into an MA or Part D Plan, it would be inappropriate for that TPMO to share the beneficiary's data with a second TPMO without the beneficiary's consent, even if that second TPMO does not plan to conduct any marketing or enrollment activities. Consent would be needed for each TPMO in the marketing enrollment chain. Selling data would potentially implicate Anti-Kickback statute.
    a. C/R: TPMOs should use a consent method where the default selection is that the beneficiary chooses to not share their data; there should be an affirmative action by the beneficiary to acknowledge that sharing their data with another TPMO is permitted.
        i. A check box list can be provided that allows beneficiaries to choose each TPMO they want to hear from.

Compliance Requirements - Medicare continued

Agents may not:

- Contact a beneficiary at his/her home which is door-to-door solicitation unless an appointment at the beneficiary's home at the applicable date and time was previously scheduled.
- Distribute or accept Scope of Appointment (SOA) and scheduling future marketing appointments at educational events is prohibited.
- SOAs and Business Reply Cards (BRCs) are only valid up to 12 months from the beneficiary's signature date or the beneficiary's request for more information.
- Hold a marketing event within 12 hours of an educational event in the same location.

Agents must:

- Wait a minimum of 48 hours after the SOA was completed by the beneficiary. Exception: When a beneficiary requests an appointment within four days of the end of a valid election period; including AEP, OEP, SEP, ICEP or month, based on eligibility and when a beneficiary initiates (walk in) an in-person meeting.
- Go through the CMS-developed list of topics that must be discussed prior to an enrollment, specifically topics about providers and whether a beneficiary's current or preferred providers or pharmacies are in-network, costs and premiums for prescription drug coverage and health care coverage, benefits, and the beneficiary's specific health care needs and current medications.
- Review the Pre-Enrollment Checklist (PECL) in its entirety with the beneficiary/enrollee and reference the effect on the enrollees current coverage.
- Record all sales, marketing and enrollment calls, in their entirety, including calls via web-based technology.

Compliance Requirements - Marketplace

HHS proposes to require agents, brokers, or web-brokers assisting with enrollment through the FFE or SBE-FPs or assisting an individual with applying for APTC and CSR in a QHP to document that the eligibility information has been reviewed by and confirmed accurate by the consumer or their authorized representative prior to submission.

Documentation would be created by the assisting agent, broker, or web-broker and would require the consumer or their authorized representative to take an action, either a signature or recorded verbal confirmation, that produces a record that can be maintained by the agent, broker, or web-broker. The documentation must include:

- The date the information was reviewed,
- The name of the consumer or their authorized representative,
- An explanation of the attestations at the end of the eligibility application, and
- The name of the agent, broker, or web-broker providing assistance.

The agent, broker, or web-broker would be required to maintain the documentation for a minimum of 10 years.

HHS proposes to require agents, brokers, or web-brokers assisting with enrollment through the FFE or SBE-FPs or assisting an individual with applying for APTC and CSR in a QHP to document the receipt of consent from the consumer or their authorized representative.

Documentation of consent would be created by the assisting agent, broker, or web-broker and would require the consumer or their authorized representative to take an action, either a signature or recorded verbal confirmation, that produces a record that can be maintained by the agent, broker, or web-broker. The documentation must include:

The date consent was given,

- The name of the consumer or their authorized representative,
- The name of the agent, broker, web-broker, or agency granted consent,
- A description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative, and
- A process by which the consumer or their authorized representative may rescind consent.

The agent, broker, or web-broker would be required to maintain the documentation for a minimum of 10 years.

Disclaimer

As a CareSource agent, you are responsible for:

- Reviewing compliance and other related updates on the Producer's Portal.
- Reviewing the Producer's Guide, for policy updates as well as how to do business with CareSource, which may be found on the Producer's Portal.
- Reviewing CareSource's Non-Discrimination policy, including Accessibility for Limited English Proficient (LEP) individuals and individuals with a disability, which may be found on **CareSource.com**. If a beneficiary needs translation assistance, or materials in another format such as braille, large print, data and audio files, relay services and TTY communications, agent and beneficiary may call Member Services using the phone number applicable to their specific state, which may be found on **CareSource.com/members/contact-us/**.
- Reviewing HIPAA Privacy Practices, which may be found on **CareSource.com/about-us/legal/hipaa-privacy-practices/**.
- Be vigilant about Fraud, Waste and Abuse (FWA) and how to report it if you become aware of it:
- Email: fraud@CareSource.com Call: 1-800-418-0248
  Send a letter to: CareSource Attn: Program Integrity PO Box 1940, Dayton, OH 45401-1940

Health Savings Accounts (HSAs) are a tax advantaged health care account that you own. HSA contributions are subject to limits established by the Internal Revenue Service (IRS). The funds you contribute, but do not use, roll over year to year. Please consult your tax advisor for guidance and review IRS Publication 969 at www.irs.gov.

IMPORTANT REMINDER FOR HDHP HSA PLANS:
Your coverage includes a preventive drug benefit. This means that preventive drugs (medications to help prevent chronic conditions and illnesses) are covered outside of your plan's deductible.
These drugs can, at times be prescribed for treatment purposes. As a result, the listing of a drug does not mean that it will be covered by your benefit plan before your HDHP deductible is satisfied. If your doctor has prescribed a listed drug for treatment purposes (and not preventive purposes) then your plan does not provide coverage for that drug before your HDHP deductible is satisfied. Please be reminded that Health Savings Accounts (HSAs) have tax and legal ramifications. [CareSource/HAP CareSource] cannot guarantee or provide any legal advice on the way these products are prescribed for preventive purposes or that the IRS would agree that all satisfy the definition under §223 NOTICE 2019-45.
As everyone's medical circumstances are different, and because proper classification is necessary for you to ensure you are complying with applicable HDHP tax regulations, it is important for you to confirm the purpose of the prescription with your doctor. Please call the number on your member ID card when your doctor confirms for you that they prescribed one of the listed drugs for treatment purposes so your claims can be processed correctly. Unless you provide us with this information, claims for the drugs listed in the will be processed as "preventive," and you or your doctor may be asked by us to provide medical records showing that the drug you're taking is being used for prevention. Remember, if you improperly classify the drug, it may result in adverse tax consequences so please be sure to take the confirming step to properly classify your claim.
Please follow these steps to make sure you are properly classifying the purpose of your prescription:
1. Find your drug on the list.
2. Talk to your doctor about whether your drug is in fact being prescribed for preventive purposes (and not treatment purposes).
3. If prescribed for treatment purposes, call the number on your member ID card to let us know.
4. If prescribed for preventive purposes, there is no need to call.

This is a solicitation for health insurance. CareSource Marketplace plans have exclusions, limitations, reductions and terms under which the policy may be continued in force or discontinued. Premiums, deductibles, coinsurance and copays may vary based upon individual circumstances and plan selection. Benefits and costs vary based upon plan selection. Not all plans and products offered by CareSource cover the same services and benefits. Covered services and benefits may vary for each plan. For costs and complete details of coverage, please review CareSource's 2025 Evidence of Coverages and Schedules of Benefits documents at CareSource.com/Marketplace.

For costs and further details of the coverage, including exclusions, any reductions or limitations and terms under which the policy may be continued in force, see your agent or write to the company.

CareSource does not discriminate on the basis of race, color, national origin, disability, age, gender, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

CareSource is a Qualified Health Plan Issuer in the Health Insurance Marketplace. Health Insurance Marketplace

Appendix

CareSource®

Telehealth

- Through our Zero Cost Telehealth Partner Program, you have access to $0 copay telehealth office visits through Teladoc®.
- Other telehealth office and non-office visits have the same cost share as your primary care provider (PCP) in-person visit.
- CareSource fully supports your choice to use telehealth and is willing to partner with your provider. We provide access to services for all members.
- Our Zero Cost Telehealth Partner provides 24/7/365 access to U.S.-licensed physicians who can consult, diagnose and prescribe medications by phone or video for short-term illnesses.

Pediatric Vision Benefits

All CareSource Marketplace plans provide pediatric vision benefits.

With the CareSource pediatric vision benefit, kids can learn, grow and succeed through healthy eye care habits. We even provide coverage for replacement eyewear if it's medically necessary.

Vision Care Services	In-Network Member Cost
Exam with Dilation as Necessary	$0 copay. Retinal imaging at no member cost share.
Contact Lenses Fit and Follow-up Standard contact lenses Premium contact lenses	 Up to $40 copay. 10% off retail price.
Frames Any available frame at a provider location	100% coverage for provider-designated frames.
Standard Plastic Lenses Single vision Bifocal Trifocal Lenticular Progressive	 $0 copay. $0 copay. $0 copay. $0 copay. See fixed premium progressive price list.
Contact Lenses (includes materials only for one of the options below) Conventional Extended wear disposables Daily wear / disposable	 100% coverage for provider-designated contact lenses. Six-month supply of monthly or two-week disposable, single vision, spherical or toric contact lenses. Three-month supply of daily disposable, single vision, spherical contact lenses.
Frequency Examination Eyewear (eyeglasses or contacts)	 Once every calendar year. Once every calendar year.
Replacement Glasses	If medically necessary, 1 replacement for glasses as outlined above.

Additional savings...

40% off additional pair discount*

20% off non-prescription sunglasses*

*These discounts are offered at in-network providers only. Discounts are not funded by CareSource.

See benefit summary details for full list of vision care services.