Indiana
2017 Summary of Benefits

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SECTION I – INTRODUCTION TO SUMMARY OF BENEFITS

The following applies to CareSource Advantage ® (HMO), CareSource Advantage Plus™ (HMO) and CareSource Advantage Zero Premium ™ (HMO)	
You have choices about how to get your Medicare benefits	• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government. • Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **CareSource Advantage, CareSource Advantage Plus** and **CareSource Advantage Zero Premium**).
Tips for comparing your Medicare choices	This Summary of Benefits booklet gives you a summary of what **CareSource Advantage , CareSource Advantage Plus** and **CareSource Advantage Zero Premium** cover and what you pay. • If you want to compare our plans with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov. • If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy 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.
Sections in this booklet	• Things to Know About **CareSource Advantage, CareSource Advantage Plus** and **CareSource Advantage Zero Premium** • Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services • Covered Medical and Hospital Benefits • Prescription Drug Benefits
Customer Service	• This document is available in other formats such as Braille and large print. • This document may be available in a non-English language. For additional information, call us at 1-800-418-0172 (TTY/TDD users should call 1-800-743-3333 or 711). • Es posible que este documento esté disponible en un idioma distinto al inglés. Para obtener información adicional, llame a servicio al cliente al 1-800-418-0172 (Los usuarios de TTY / TDD deben llamar al 1-800-743-3333 or 711).
Hours of Operation	Things to Know About **CareSource Advantage, CareSource Advantage Plus** and **CareSource Advantage Zero Premium** • From Oct.1 to Feb.14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time. • From Feb.15 to Sept.30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.
Contact Information	**CareSource Advantage, CareSource Advantage Plus** and **CareSource Advantage Zero Premium** Phone Numbers and Website • If you are a member of one of these plans, call toll-free 1-800-418-0172 TTY/TDD: 1-800-743-3333 or 711. • If you are not a member of one of these plans, call toll-free 1-888-320-9397 TTY/TDD: 1-800-743-3333 or 711 Our website: **CareSource.com/medicare**

The following applies to CareSource Advantage, CareSource Advantage Plus and CareSource Advantage Zero Premium	
Service Area	**Who can join?** To join **CareSource Advantage, CareSource Advantage Plus** or **CareSource Advantage Zero Premium,** you must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties in Indiana: Adams, Allen, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Decatur, DeKalb, Delaware, Fayette, Floyd, Fountain, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Huntington, Jackson, Jay, Jennings, Johnson, Lawrence, Madison, Marion, Martin, Miami, Monroe, Montgomery, Morgan, Orange, Owen, Parke, Pulaski, Putnam, Randolph, Rush, Scott, Shelby, Starke, Sullivan, Tippecanoe, Tipton, Union, Wabash, Warren, Washington, Wells, White and Whitley **Which doctors, hospitals and pharmacies can I use?** **CareSource Advantage, CareSource Advantage Plus** and **CareSource Advantage Zero Premium** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers not in our network, the plans may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plans' provider directories at our website: www.caresource.com/medicare You can see our plans' pharmacy directories at our website: **CareSource.com/medicare** Or, call us and we will send you a copy of the provider and pharmacy directories.

The following applies to CareSource Advantage, CareSource Advantage Plus and CareSource Advantage Zero Premium	
	What do we cover? Like all Medicare health plans, we cover everything that Original Medicare covers — and more. Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plans than you would in Original Medicare. For others, you may pay less. Our plan members also get more than what is covered by Original Medicare. Some of the extra benefits are outlined in this booklet. We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.caresource.com/medicare. Or, call us and we will send you a copy of the formulary. **How will I determine my drug costs?** Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document, we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

SECTION II – SUMMARY OF BENEFITS

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
How much is the monthly premium?	$32.10 per month. In addition, you must keep paying your Medicare Part B premium.	$56.60 per month. In addition, you must keep paying your Medicare Part B premium.	$0 per month. You must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.	This plan does not have a deductible.	$400 medical deductible $250 pharmacy deductible (brand-only)

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $4,600 for services you receive from in-network providers. • If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $4,600 for services you receive from in-network providers. • If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 for services you receive from in-network providers. • If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

	CareSource Advantage (HMO)	CareSource Advantage Plus (HMO)	CareSource Advantage Zero Premium
COVERED MEDICAL AND HOSPITAL BENEFITS			
NOTE: Services with a [1] may require prior authorization. Services with a [2] may require a referral from your doctor.			
Inpatient Hospital Care[1]	In-network: • $279 copay per day for days 1 through 7 • $0 copay per day for days 8 through 90 Out-of-network: 100% of the cost per stay	In-network: • $200 copay per day for days 1 through 7 • $0 copay per day for days 8 through 90 Out-of-network: 100% of the cost per stay	In-network: • $250 copay per day for days 1 through 5 • $0 copay per day for days 6 through 90 Out-of-network: 100% of the cost per stay
Doctor's Office Visits[1]	**Primary care physician visit:** • In-network: $0 copay • Out-of-network: 100% of the cost **Specialist visit:** • In-network: $50 copay • Out-of-network: 100% of the cost	**Primary care physician visit:** • In-network: $0 copay • Out-of-network: 100% of the cost **Specialist visit:** • In-network: $30 copay • Out-of-network: 100% of the cost	**Primary care physician visit:** • In-network: $10 copay • Out-of-network: 100% of the cost **Specialist visit:** • In-network: $50 copay • Out-of-network: 100% of the cost
Preventive Care	In-network: $0 copay Out-of-network: 100% of the cost Our plan covers many preventive services, including: • Abdominal Aortic Aneurysm Screening; • Adult Immunizations; • Annual Wellness Visit Including Personalized Prevention Plan Services; • Bone Mass Measurements; • Cancer Screenings; • Cardiovascular Screening; • Diabetes Screening; • Diabetes Self-Management Training;	In-network: $0 copay Out-of-network: 100% of the cost Our plan covers many preventive services, including: • Abdominal Aortic Aneurysm Screening; • Adult Immunizations; • Annual Wellness Visit Including Personalized Prevention Plan Services; • Bone Mass Measurements; • Cancer Screenings; • Cardiovascular Screening; • Diabetes Screening; • Diabetes Self-Management Training;	In-network: $0 copay Out-of-network: 100% of the cost Our plan covers many preventive services, including: • Abdominal Aortic Aneurysm Screening; • Adult Immunizations; • Annual Wellness Visit Including Personalized Prevention Plan Services; • Bone Mass Measurements; • Cancer Screenings; • Cardiovascular Screening; • Diabetes Screening;

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Preventive Care (continued)	• Glaucoma Screening; • HIV Screening; • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam); • Intensive Behavioral Therapy for Cardiovascular Disease; • Intensive Behavioral Therapy for Obesity; • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease); • Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse; • Screening for Depression in Adults; • Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs; and • Tobacco-Use Cessation Counseling Services • Cancer Screenings to include:Mammograms, Cervical and vaginal cancer screening • Cardiovascular screenings include: Cardiovascular disease testing and therapy for cardiovascular disease Any additional preventive services approved by Medicare during the contract year will be covered.	• Glaucoma Screening; • HIV Screening; • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam); • Intensive Behavioral Therapy for Cardiovascular Disease; • Intensive Behavioral Therapy for Obesity; • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease); • Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse; • Screening for Depression in Adults; • Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs; and • Tobacco-Use Cessation Counseling Services • Cancer Screenings to include:Mammograms, Cervical and vaginal cancer screening • Cardiovascular screenings include: Cardiovascular disease testing and therapy for cardiovascular disease Any additional preventive services approved by Medicare during the contract year will be covered.	• Glaucoma Screening; • HIV Screening; • Initial Preventive Physical Exam ("Welcome to Medicare" Physical Exam); • Intensive Behavioral Therapy for Cardiovascular Disease; • Intensive Behavioral Therapy for Obesity; • Medical Nutrition Therapy (for Medicare beneficiaries with diabetes or renal disease); • Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse; • Screening for Depression in Adults; • Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling to Prevent STIs; and • Tobacco-Use Cessation Counseling Services • Cancer Screenings to include:Mammograms, Cervical and vaginal cancer screening • Cardiovascular screenings include: Cardiovascular disease testing and therapy for cardiovascular disease Any additional preventive services approved by Medicare during the contract year will be covered.

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Emergency Care	$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.	$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.	$75 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the “Inpatient Hospital Care” section of this booklet for other costs.
Urgent Care	$35 copay	$25 copay	$65 copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	**Diagnostic radiology services** (such as MRIs, CT scans): • In-network: $175 copay • Out-of-network: 100% of the cost **Diagnostic tests and procedures:** • In-network: $0 copay • Out-of-network: 100% of the cost **Lab services:** • In-network: $0 copay • Out-of-network: 100% of the cost **Outpatient x-rays:** • In-network: $25 copay • Out-of-network: 100% of the cost **Therapeutic radiology services (such as radiation treatment for cancer):** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Diagnostic radiology services** (such as MRIs, CT scans): • In-network: $175 copay • Out-of-network: 100% of the cost **Diagnostic tests and procedures:** • In-network: $0 copay • Out-of-network: 100% of the cost **Lab services:** • In-network: $0 copay • Out-of-network: 100% of the cost **Outpatient x-rays:** • In-network: $25 copay • Out-of-network: 100% of the cost **Therapeutic radiology services (such as radiation treatment for cancer):** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Diagnostic radiology services** (such as MRIs, CT scans): • In-network: $175 copay • Out-of-network: 100% of the cost **Diagnostic tests and procedures:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Lab services:** • In-network: $0 copay • Out-of-network: 100% of the cost **Outpatient x-rays:** • In-network: $50 copay • Out-of-network: 100% of the cost **Therapeutic radiology services (such as radiation treatment for cancer):** • In-network: 20% of the cost (not subject to the deductible) • Out-of-network: 100% of the cost

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Hearing Services[1]	**Exam to diagnose and treat hearing and balance issues:** • In-network: $50 copay • Out-of-network: 100% of the cost **Routine hearing exam** (for up to 1 every year): • In-network: $0 copay • Out-of-network: 100% of the cost **Hearing aid fitting/ evaluation:** • In-network: $0 copay • Out-of-network: 100% of the cost **Hearing aid:** • In-network: $0 copay • Out-of-network: 100% of the cost Our plan pays up to $500 every three years for hearing aids from any provider.	**Exam to diagnose and treat hearing and balance issues:** • In-network: $30 copay • Out-of-network: 100% of the cost **Routine hearing exam** (for up to 1 every year): • In-network: $0 copay • Out-of-network: 100% of the cost **Hearing aid fitting/ evaluation:** • In-network: $0 copay • Out-of-network: 100% of the cost **Hearing aid:** • In-network: $0 copay • Out-of-network: 100% of the cost Our plan pays up to $800 every three years for hearing aids from any provider.	**Exam to diagnose and treat hearing and balance issues:** • In-network: $50 copay • Out-of-network: 100% of the cost **Routine hearing exam** (for up to 1 every year): • In-network: $0 copay • Out-of-network: 100% of the cost **Hearing aid fitting/ evaluation:** • In-network: $20 copay • Out-of-network: 100% of the cost **Hearing aid:** • In-network: $0 copay • Out-of-network: 100% of the cost Our plan pays up to $150 every three years for hearing aids from any provider.

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Dental Services[1]	**Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $50 copay • Out-of-network: 100% of the cost **In-network preventive dental services** have a $10 copay for a single office visit that includes: • Cleaning (for up to 1 every 6 months) • Dental x-ray(s) (for up to 1 every year) • Oral exam (for up to 1 every 6 months) • Out-of-network: 100% of the cost	**Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $30 copay • Out-of-network: 100% of the cost **In-network preventive dental services** have a $10 copay for a single office visit that includes: • Cleaning (for up to 1 every 6 months) • Dental x-ray(s) (for up to 1 every year) • Oral exam (for up to 1 every 6 months) • Out-of-network: 100% of the cost	**Limited dental services** (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: $50 copay • Out-of-network: 100% of the cost **In-network preventive dental services** have a $10 copay for a single office visit that includes: • Cleaning (for up to 1 every 6 months) • Dental x-ray(s) (for up to 1 every year) • Oral exam (for up to 1 every 6 months) • Out-of-network: 100% of the cost

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Vision Services	**Exam to diagnose and treat diseases and conditions of the eye** (including yearly glaucoma screening): • In-network: $50 copay • Out-of-network: 100% of the cost **Routine eye exam** (for up to 1 every year): • In-network: $25 copay • Out-of-network: 100% of the cost **Contact lenses** (for up to 1 every year): • In-network: $0 copay up to $100 allowance • Out-of-network: 100% of the cost **Eyeglasses (frames and lenses)** (for up to 1 every year): • In-network: $0 copay up to $100 allowance every year for contact lenses and eyeglasses (frames and lenses) • Out-of-network: 100% of the cost **Eyeglasses or contact lenses after cataract surgery** • In-network: $50 copay • Out-of-network: 100% of the cost	**Exam to diagnose and treat diseases and conditions of the eye** (including yearly glaucoma screening): • In-network: $30 copay • Out-of-network: 100% of the cost **Routine eye exam** (for up to 1 every year): • In-network: $25 copay • Out-of-network: 100% of the cost **Contact lenses** (for up to 1 every year): • In-network: $0 copay up to $100 allowance • Out-of-network: 100% of the cost **Eyeglasses (frames and lenses)** (for up to 1 every year): • In-network: $0 copay up to $100 allowance every year for contact lenses and eyeglasses (frames and lenses) • Out-of-network: 100% of the cost **Eyeglasses or contact lenses after cataract surgery** • In-network: $30 copay • Out-of-network: 100% of the cost	**Exam to diagnose and treat diseases and conditions of the eye** (including yearly glaucoma screening): • In-network: $50 copay • Out-of-network: 100% of the cost **Routine eye exam** (for up to 1 every year): • In-network: $25 copay • Out-of-network: 100% of the cost **Contact lenses** (for up to 1 every year): • In-network: $0 copay up to $100 allowance • Out-of-network: 100% of the cost **Eyeglasses (frames and lenses)** (for up to 1 every year): • In-network: $0 copay up to $100 allowance every year for contact lenses and eyeglasses (frames and lenses) • Out-of-network: 100% of the cost **Eyeglasses or contact lenses after cataract surgery** • In-network: $50 copay • Out-of-network: 100% of the cost

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Mental Health Care[1]	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. • In-network: – $220 copay per day for days 1 through 7 – $0 copay per day for days 8 through 90 • Out-of-network: 100% of the cost per stay **Outpatient group therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost **Outpatient individual therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. • In-network: – $220 copay per day for days 1 through 7 – $0 copay per day for days 8 through 90 • Out-of-network: 100% of the cost per stay **Outpatient group therapy visit:** • In-network: $30 copay • Out-of-network: 100% of the cost **Outpatient individual therapy visit:** • In-network: $30 copay • Out-of-network: 100% of the cost	**Inpatient visit:** Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. • In-network: – $250 copay per day for days 1 through 5 – $0 copay per day for days 6 through 90 • Out-of-network: 100% of the cost per stay **Outpatient group therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost **Outpatient individual therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost
Skilled Nursing Facility (SNF)[1]	**Our plan covers up to 100 days in a SNF.** • In-network: – $0 copay per day for days 1 through 20 – $160 copay per day for days 21 through 100 • Out-of-network: 100% of the cost per stay	**Our plan covers up to 100 days in a SNF.** • In-network: – $0 copay per day for days 1 through 20 – $160 copay per day for days 21 through 100 • Out-of-network: 100% of the cost per stay	**Our plan covers up to 100 days in a SNF.** • In-network: – $0 copay per day for days 1 through 20 – $161 copay per day for days 21 through 100 • Out-of-network: 100% of the cost per stay

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Outpatient Rehabilitation[1]	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: 100% of the cost **Occupational therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost **Physical therapy and speech and language therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $0 copay • Out-of-network: 100% of the cost **Occupational therapy visit:** • In-network: $30 copay • Out-of-network: 100% of the cost **Physical therapy and speech and language therapy visit:** • In-network: $25 copay • Out-of-network: 100% of the cost	**Cardiac (heart) rehab services** (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: 20% of the cost • Out-of-network: 100% of the cost **Occupational therapy visit:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Physical therapy and speech and language therapy visit:** • In-network: 20% of the cost • Out-of-network: 100% of the cost
Ambulance[1]	In-network: $250 copay Out-of-network: $250 copay	In-network: $225 copay Out-of-network: $225 copay	In-network: $275 copay Out-of-network: $275 copay
Transportation	Not covered	Not covered	Not covered
Foot Care (podiatry services)[1]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $50 copay • Out-of-network: 100% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $30 copay • Out-of-network: 100% of the cost	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $45 copay • Out-of-network: 100% of the cost
Durable Medical Equipment (wheelchairs, oxygen, etc.)[1]	In-network: 20% of the cost Out-of-network: 100% of the cost	In-network: 20% of the cost Out-of-network: 100% of the cost	In-network: 20% of the cost (no deductible) Out-of-network: 100% of the cost

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Prosthetic Devices (braces, artificial limbs, etc.)[1]	**Prosthetic devices:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Related medical supplies:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Prosthetic devices:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Related medical supplies:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Prosthetic devices:** • In-network: 20% of the cost (not subject to deductible) • Out-of-network: 100% of the cost **Related medical supplies:** • In-network: 20% of the cost (not subject to deductible) • Out-of-network: 100% of the cost
Diabetes Supplies and Services	**Diabetes monitoring supplies:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Diabetes self-management training:** • In-network: $0 copay • Out-of-network: 100% of the cost **Therapeutic shoes or inserts:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Diabetes monitoring supplies:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Diabetes self-management training:** • In-network: $0 copay • Out-of-network: 100% of the cost **Therapeutic shoes or inserts:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**Diabetes monitoring supplies:** • In-network: 20% of the cost (not subject to the deductible) • Out-of-network: 100% of the cost **Diabetes self-management training**: • In-network: 20% of the cost • Out-of-network: 100% of the cost **Therapeutic shoes or inserts:** • In-network: 20% of the cost (not subject to the deductible) • Out-of-network: 100% of the cost
Wellness	$0 copay for fitness benefit or home health kit when using an approved network fitness center or gym.	$0 copay for fitness benefit or home health kit when using an approved network fitness center or gym.	$0 copay for fitness benefit or home health kit when using an approved network fitness center or gym.

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
OTHER BENEFITS			
Acupuncture	Not covered	Not covered	Not covered
Chiropractic Care[1]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 100% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: 100% of the cost	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: 20% of the costs • Out-of-network: 100% of the cost
Home Health Care[1]	In-network: $0 copay Out-of-network: 100% of the cost	In-network: $0 copay Out-of-network: 100% of the cost	In-network: $0 copay Out-of-network: 100% of the cost
Hospice	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare certified hospice. You may have to pay part of the costs for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
Outpatient Substance Abuse[1]	**Group therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost **Individual therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost	**Group therapy visit:** • In-network: $30 copay • Out-of-network: 100% of the cost **Individual therapy visit:** • In-network: $30 copay • Out-of-network: 100% of the cost	**Group therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost **Individual therapy visit:** • In-network: $40 copay • Out-of-network: 100% of the cost
Outpatient Surgery[1]	**Ambulatory surgical center:** • In-network: $200 copay • Out-of-network: 100% of the cost **Outpatient hospital:** • In-network: $250 copay • Out-of-network: 100% of the cost	**Ambulatory surgical center:** • In-network: $100 copay • Out-of-network: 100% of the cost **Outpatient hospital:** • In-network: $225 copay • Out-of-network: 100% of the cost	**Ambulatory surgical center:** • In-network: $250 copay • Out-of-network: 100% of the cost **Outpatient hospital:** • In-network: 20% of the cost • Out-of-network: 100% of the cost

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Over-the-Counter Items	Not covered	Not covered	Not covered
Renal Dialysis	In-network: 20% of the cost Out-of-network: 100% of the cost	In-network: 20% of the cost Out-of-network: 100% of the cost	In-network: 20% of the cost (not subject to deductible) Out-of-network: 100% of the cost
PRESCRIPTION DRUG BENEFITS			
How much do I pay?	**For Part B drugs such as chemotherapy drugs:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Other Part B drugs:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**For Part B drugs such as chemotherapy drugs:** • In-network: 20% of the cost • Out-of-network: 100% of the cost **Other Part B drugs:** • In-network: 20% of the cost • Out-of-network: 100% of the cost	**For Part B drugs such as chemotherapy drugs:** • In-network: 20% of the cost (not subject to deductible) • Out-of-network: 100% of the cost **Other Part B drugs:** • In-network: 20% of the cost (not subject to deductible) Out-of-network: 100% of the cost
Initial Coverage	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.	You pay the following until your total yearly drug costs reach $3,700. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies. If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Initial Coverage (continued)	CareSource Advantage		CareSource Advantage Plus		CareSource Advantage Zero Premium	
	One-month Supply	Three-month Supply	One-month Supply	Three-month Supply	One-month Supply	Three-month Supply
Tier 1 (Preferred Generic)	$4 copay	$12 copay	$0 copay	$0 copay	$6 copay	$18 copay
Tier 2 (Generic)	$10 copay	$30 copay	$10 copay	$30 copay	$15 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4 (Non-Preferred Drug)	$100 copay	$300 copay	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	33% of the cost	33% of the cost	28% of the cost	28% of the cost

Initial Coverage (continued)	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
	Standard Mail Order Cost-Sharing		
	Three-month Supply	Three-month Supply	Three-month Supply
Tier 1 (Preferred Generic)	$10 copay	$0 copay	$15 copay
Tier 2 (Generic)	$25 copay	$25 copay	$37.50 copay
Tier 3 (Preferred Brand)	$117.50 copay	$117.50 copay	$117.50 copay
Tier 4 (Non-Preferred Drug)	$250 copay	$250 copay	$250 copay
Tier 5 (Specialty Tier)	33% of the cost	33% of the cost	28% of the cost
Cost-Sharing may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost-sharing and the phases of the benefit, please call us toll-free at 1-800-418-0172 TTY/TDD: 1-800-743-3333 or 711 or access our website **CareSource.com/medicare.**			

	CareSource Advantage	CareSource Advantage Plus	CareSource Advantage Zero Premium
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,700. After you enter the coverage gap, you pay 40% of the plan's cost for covered brand name drugs and 51% of the plan's cost for covered generic drugs until your costs total $4,950, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost, or • $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost, or • $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,950, you pay the greater of: • 5% of the cost, or • $3.30 copay for generic (including brand drugs treated as generic) and a $8.25 copayment for all other drugs.

SPANISH

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-418-0172 TTY:711.

ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-418-0172 TTY:711.

CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-418-0172 TTY:711。

GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-418-0172 TTY:711.

ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة, فإن خدمات المساعدة اللغوية تتوافر للك بالمجان. اتصل برقم 1-800-418-0172, رقم هاتف الصم والبكم: 711.

PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-418-0172 TTY:711.

RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-418-0172 телетайп: 771.

FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-418-0172 TTY:711.

VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-418-0172 TTY:711.

CUSHITE/OROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-418-0172 TTY:711.

KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-418-0172 TTY:711 번으로 전화해 주십시오.

ITALIAN

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-418-0172 TTY:711.

JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-418-0172 TTY:711まで、お電話にてご連絡ください。

DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-418-0172 TTY:711.

UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-418-0172 телетайп:711.

ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-418-0172 TTY:711.

NEPALI

ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-418-0172 टटिवाइ: 711 ।

SOMALI

DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqada, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-800-418-0172 TTY: 711.

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CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please contact CareSource at 1-800-418-0172 (1-800-743-3333 or TTY: 711).

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401
1-844-539-1732, TTY: 711
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

CareSource - H9162

2017 Medicare Star Ratings*

The Medicare Program rates all health and prescription drug plans each year, based on a plan's quality and performance. Medicare Star Ratings help you know how good a job our plan is doing. You can use these Star Ratings to compare our plan's performance to other plans. The two main types of Star Ratings are:

1. An Overall Star Rating that combines all of our plan's scores.
2. Summary Star Rating that focuses on our medical or our prescription drug services.

Some of the areas Medicare reviews for these ratings include:

- How our members rate our plan's services and care;
- How well our doctors detect illnesses and keep members healthy;
- How well our plan helps our members use recommended and safe prescription medications.

For 2017, CareSource received the following Overall Star Rating from Medicare.

Plan too new to be measured

We received the following Summary Star Rating for CareSource's health/drug plan services:

Health Plan Services:	Plan too new to be measured
Drug Plan Services:	Plan too new to be measured

The number of stars shows how well our plan performs.

★★★★★	5 stars - excellent
★★★★	4 stars - above average
★★★	3 stars - average
★★	2 stars - below average
★	1 star - poor

Learn more about our plan and how we are different from other plans at www.medicare.gov.

You may also contact us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 1-888-320-9397 (toll-free) or 1-800-743-3333 (TTY), from October 1 to February 14. Our hours of operation from February 15 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

Current members please call 1-800-418-0172 (toll-free) or 1-800-743-3333 (TTY).

*Star Ratings are based on 5 Stars. Star Ratings are assessed each year and may change from one year to the next.

Call Member Services at 1-800-418-0172 (TTY: 1-800-743-3333). We are open 8 a.m.- 8 p.m. Monday through Friday, and from Oct. 1 – Feb. 14 we are open the same hours 7 days a week.

CareSource.com/Medicare

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