

CareSource Dual Advantage™ (HMO D-SNP)

# 2025 ENROLLMENT GUIDE

OHIO





**Typically, you may enroll in a Medicare Advantage plan only during the Annual Election Period (AEP) from October 15 through December 7 of each year.** There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- I am new to Medicare.
- I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- I recently moved outside of the service area for my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) \_\_\_\_\_.
- I recently was released from incarceration. I was released on (insert date) \_\_\_\_\_.
- I recently returned to the United States (U.S.) after living permanently outside of the U.S. I returned to the U.S. on (insert date) \_\_\_\_\_.
- I recently obtained lawful presence status in the United States. I got this status on (insert date) \_\_\_\_\_.
- I recently had a change in my Medicaid (e.g., newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date) \_\_\_\_\_.
- I recently had a change in my Extra Help paying for Medicare prescription drug coverage (e.g., newly got Extra Help, had a change in the level of Extra Help or lost Extra Help) on (insert date) \_\_\_\_\_.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums, or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- I am moving into, live in or recently moved out of a Long-Term Care (LTC) Facility (e.g., a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) \_\_\_\_\_.
- I recently left a Program of All-Inclusive Care for the Elderly (PACE) program on (insert date) \_\_\_\_\_.

- I recently involuntarily lost my creditable prescription drug coverage (e.g., coverage as good as Medicare's). I lost my drug coverage on (insert date) \_\_\_\_\_.
- I am leaving employer or union coverage on (insert date) \_\_\_\_\_.
- I belong to a pharmacy assistance program provided by my state.
- My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- I was enrolled in a plan by Medicare or my state, and I want to choose a different plan. My enrollment in that plan started on (insert date) \_\_\_\_\_.
- I was enrolled in a Special Needs Plan (SNP), but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) \_\_\_\_\_.
- I was affected by an emergency or major disaster as declared by the Federal Emergency Management Agency (FEMA) or by a Federal, state or local government entity. One of the other statements here applied to me, but I was unable to make my enrollment request because of the natural disaster.
- I'm in a plan that's had a star rating of less than 3 stars for the last 3 years. I want to join a plan with a star rating of 3 stars or higher.
- I'm in a plan that was recently taken over by the state because of financial issues. I want to switch to another plan.

If none of these statements apply to you or you're not sure, please contact CareSource at **1-844-829-6903** (TTY users should call **1-833-711-4711 or 711**) 8 a.m. to 8 p.m. Monday through Friday, and from October 1 to March 31, we are open the same hours, seven days a week.

## Who can use this form?

People with Medicare who want to join a Medicare Advantage Plan.

### To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area

**Important:** To join a Medicare Advantage Plan, you must also have both:

- Medicare Part A (Hospital Insurance)
- Medicare Part B (Medical Insurance)

## When do I use this form?

You can join a plan:

- Between October 15–December 7 each year (for coverage starting January 1)
- Within 3 months of first getting Medicare
- In certain situations where you're allowed to join or switch plans

Visit [Medicare.gov](https://www.Medicare.gov) to learn more about when you can sign up for a plan.

## What do I need to complete this form?

- Your Medicare Number. (The number on your red, white and blue Medicare card)
- Your permanent address and phone number

**Note:** You must complete all items in Section 1. The items in Section 2 are optional — you can't be denied coverage because you don't fill them out.

## Reminders:

- If you want to join a plan during fall open enrollment (October 15–December 7), the plan must get your completed form by December 7.
- Your plan will send you a bill for the plan's premium. You can choose to sign up to have your premium payments deducted from your bank account or your monthly Social Security (or Railroad Retirement Board) benefit.

## What happens next?

Send your completed and signed form to:

CareSource Enrollment  
P.O. Box 1294  
Dayton, OH 45401-9903

Once they process your request to join, they'll contact you.

## How do I get help with this form?

Call CareSource at **1-844-829-6903**.

TTY users can call **1-833-711-4711 or 711**.

Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

**En español:** Llame a CareSource al **1-844-829-6903 (TTY: 1-833-711-4711 or 711)** o a Medicare gratis al 1-800-633-4227 y oprima el 8 para asistencia en español y un representante estará disponible para asistirle.

## Individuals experiencing homelessness

If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1378. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

### IMPORTANT

**Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed or forwarded to the plan. See "What happens next?" on this page to send your completed form to the plan.**

## Section 1 – All fields on this page are required (unless marked optional)

### Select the plan you want to join:

CareSource Dual Advantage™ (HMO D-SNP)

FIRST name:

LAST name:

Optional: Middle Initial:

Birth date: (MM/DD/YYYY)  
( / / )

Sex:  
 Male  Female

Phone number:  
( )

**Permanent Residence street address** (Don't enter a PO Box. **Note:** For individuals experiencing homelessness, a PO Box may be considered your permanent resident address.):

City:

Optional: County:

State:

ZIP Code:

**Mailing address, if different from your permanent address (PO Box allowed):**

Street Address:

City:

State:

ZIP Code:

## Your Medicare information:

**Medicare Number:** \_ \_ \_ \_ \_ - \_ \_ \_ \_ - \_ \_ \_ \_ \_

## Answer these important questions:

Will you have other prescription drug coverage (like VA, TRICARE) in addition to CareSource?

Yes  No

Name of other coverage: \_\_\_\_\_

Member number for this coverage: \_\_\_\_\_

Group number for this coverage: \_\_\_\_\_

Are you presently on Medicaid?

Yes  No

If yes, is your eligibility level one of the following?

QMB  QMB+  FBDE  SLMB+

**Medicaid Number (length varies by state):**

## IMPORTANT: Read and sign below:

- I must keep both Hospital (Part A) and Medical (Part B) to stay in CareSource.
- By joining this Medicare Advantage, I acknowledge that CareSource will share my information with Medicare, who may use it to track my enrollment, to make payments and for other purposes allowed by Federal law that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.
- I understand that I can be enrolled in only one MA plan at a time – and that enrollment in this plan will automatically end my enrollment in another MA plan (exceptions apply for MA PFFS, MA MSA plans).
- I understand that when my CareSource coverage begins, I must get all of my medical and prescription drug benefits from CareSource. Benefits and services provided by CareSource and contained in my CareSource “Evidence of Coverage” document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor CareSource will pay for benefits or services that are not covered.
- The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
  - This person is authorized under State law to complete this enrollment, and
  - Documentation of this authority is available upon request by Medicare.

**Signature:**

**Today's date:**

If you're the authorized representative, sign above and fill out these fields:

Name:

Address:

Phone number:

Relationship to enrollee:

## Section 2 – All fields on this page are optional

**Answering these questions is your choice. You can't be denied coverage because you don't fill them out.**

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin |  |
| <input type="checkbox"/> I choose not to answer                             |  |

What is your race? Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American |
| Asian:  | Native Hawaiian and Pacific Islander:              |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Guamanian or Chamorro     |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Native Hawaiian           |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Samoan                    |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> Other Pacific Islander    |
| <input type="checkbox"/> Korean                           | <input type="checkbox"/> White                     |
| <input type="checkbox"/> Vietnamese                       | <input type="checkbox"/> I choose not to answer    |
| <input type="checkbox"/> Other Asian                      |  |

What is your gender? Select one.

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Man        |  |
| <input type="checkbox"/> Non-binary | <input type="checkbox"/> I choose not to answer        |

Which of the following best represents how you think of yourself? Select one.

- |  |  |
|--|--|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know                  |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> I choose not to answer        |

Select one if you want us to send you information in a language other than English.

- Spanish

Select one if you want us to send you information in an accessible format.

- Braille                       Large print                       Audio CD                       Data CD

Please contact CareSource at **1-833-230-2020** if you need information in an accessible format other than what's listed above. Our office hours are 8 a.m. to 8 p.m., Monday through Friday, and from October 1 through March 31, we are open the same hours, seven days a week. TTY users can call **1-833-711-4711**.

Do you work?     Yes     No

Does your spouse work?     Yes     No

List your Primary Care Physician (PCP), clinic or health center:

## For individuals helping enrollee with completing this for only

Complete this section if you're an individual (i.e. agents, brokers, SHIP, counselors, family members, or other third parties) helping an enrollee fill out the form.

Name: \_\_\_\_\_ Relationship to enrollee: \_\_\_\_\_

Signature: \_\_\_\_\_

National Producer Number (Agents/Brokers only) \_\_\_\_\_

### PRIVACY ACT STATEMENT

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1851 of the Social Security Act and 42 CFR §§ 422.50 and 422.60 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.



CareSource Dual Advantage™ (HMO D-SNP)  
**Monthly Plan Premium for People who get Extra Help from Medicare  
to Help Pay for their Prescription Drug Costs**

If you get extra help from Medicare to help pay for your Medicare prescription drug plan costs, your monthly plan premium will be lower than what it would be if you did not get extra help from Medicare.

If you get extra help, your monthly plan premium will be \$0 for our CareSource Dual Advantage plan. (This does not include any Medicare Part B premium you may have to pay.)

CareSource Dual Advantage plan premium includes coverage for both medical services and prescription drug coverage.

If you aren't getting extra help, you can see if you qualify by calling:

- 1-800-Medicare or TTY users call 1-877-486-2048 (24 hours a day/7 days a week),
- Your State Medicaid Office, or
- The Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778 between 7 a.m. and 7 p.m., Monday through Friday.

If you have any questions about this notice, please contact Member Services at <1-833-230-2020 (TTY users should call 1-833-711-4711 or 711)>. We are open 8 a.m. to 8 p.m. Eastern Time (ET) Monday through Friday, and from October 1 through March 31 we are open the same hours, seven days a week.

CareSource is an HMO D-SNP with a Medicare and state Medicaid contract. Enrollment in CareSource depends on contract renewal.



## Medicare Prescription Payment Plan

There's a new prescription payment plan program you can use. The Medicare Prescription Payment Plan is a new payment option where you can pay out-of-pocket prescription drug costs in the form of monthly payments over the course of your plan year instead of all at once at the pharmacy. It's completely voluntary to join, meaning it's your choice. The program begins on January 1, 2025.

The goal is to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). There are no fees or interest if payments are made on time. **This payment option may help you manage your expenses, but it does not save you money or lower your drug costs.**

Part D enrollees who face high cost-sharing earlier in the plan year are more likely to benefit from the program. This payment option may not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Before you make a decision, consider all of your options and what might work best for you.

**In 2025, CareSource Dual Advantage members have no copays for Medicare Part D prescription drugs if you receive "Extra Help."**

To learn more visit, [CareSource.com/plans/dsnp/pharmacy/drug-cost-help/MPPP](https://www.caresource.com/plans/dsnp/pharmacy/drug-cost-help/MPPP). We're also happy to help. If you have questions, call us at **1-833-230-2020 (TTY: 1-833-711-4711 or 711)**. We are open 8 a.m. to 8 p.m. Monday through Friday, and from October 1 through March 31 we are open the same hours, seven days a week.



## Medicare Prescription Payment Plan participation request form

The Medicare Prescription Payment Plan is a voluntary payment option that works with your current drug coverage to help you manage your out-of-pocket Medicare Part D drug costs by spreading them across the calendar year (January-December). **This payment option may help you manage your expenses, but it doesn't save you money or lower your drug costs.**

This payment option might not be the best choice for you if you get help paying for your prescription drug costs through programs like Extra Help from Medicare or a State Pharmaceutical Assistance Program (SPAP). Call your plan for more information.

### Complete all fields unless marked optional

FIRST name:	LAST name:	MIDDLE initial (optional):	
Medicare Number: _ _ _ _ - _ _ _ - _ _ _ _			
Member ID Number: _ _ _ _ _ _ _ _ _ _		RxGroup Number: _ _ _ _ _ _ _ _ _ _	
Birth date: (MM/DD/YYYY) ( _ / _ / _ )		Phone number: ( _ ) ( _ ) ( _ ) ( _ )	
Permanent residence street address (don't enter a P.O. Box unless you're experiencing homelessness):			
City:	County (optional):	State:	ZIP code:
Mailing address, if different from your permanent address (P.O. Box allowed):			
Address:		City:	State: ZIP code:

### Read and sign below

- I understand this form is a request to participate in the Medicare Prescription Payment Plan. CareSource Dual Advantage™ (HMO D-SNP) will contact me if they need more information.
- I understand that signing this form means that I've read and understand the form and the attached terms and conditions.
- **CareSource Dual Advantage will send me a notice to let me know when my participation in the Medicare Prescription Payment Plan is active.** Until then, I understand that I'm not a participant in the Medicare Prescription Payment Plan.

<b>Signature:</b>	<b>Date:</b>
If you're completing this form for someone else, complete the section below. Your signature certifies that you're authorized under State law to fill out this participation form and have documentation of this authority available if Medicare asks for it.	
Name:	Address (Street, City, State, ZIP code):
Phone number: ( )	Relationship to participant:

## How to submit this form

You can also complete the participation request form online at [www.express-scripts.com/mppp](http://www.express-scripts.com/mppp) or call Express Scripts at 1-866-845-1803 to submit your request via phone.

Submit your completed form to:  
Express Scripts MPPP  
P.O. Box 801101  
Kansas City, MO 64180-1101

If you have questions or need help completing this form, call Express Scripts at 1-866-845-1803, 24 hours a day, 7 days a week. TTY users can call 1-800-716-3231.

## TERMS AND CONDITIONS:

Upon acceptance into the Medicare Prescription Payment Plan:

- We will inform your pharmacy that you're using this payment option, which will apply only to Medicare Part D covered drugs that are processed after your election is confirmed.
- When you fill a prescription for an eligible drug, you will pay zero dollars at the pharmacy, but you will still be responsible for your cost share of the drug associated with your Medicare Part D benefit under your plan.
- You will receive a monthly invoice for the amount you owe, when it's due, and information on how to make a payment.
- Your payments may change every month because your monthly bill is based on what you would have paid for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year. However, you'll never pay more than the total amount you would have paid out of pocket or the total annual out-of-pocket maximum.
- If you miss a payment, you will receive a reminder notice. If you don't pay your bill by the date listed, you will be removed from this payment option. However, you are required to pay the amount you owe, and you may not be able to elect back into this payment option.
- You can leave this payment option at any time without affecting your Medicare drug coverage and other Medicare benefits.
- You can do this by selecting Opt-out through the website or calling the phone number listed on the back of your member ID card. However, after you opt out, you will receive an invoice each month for the amount you owe until your balance is paid.
- You'll pay the pharmacy directly for new out-of-pocket drug costs after you leave this payment option.
- Participation in this payment option will automatically make you eligible for important relevant emails.
- If you are disenrolled from your Medicare Part D plan for any reason, or you enroll in a new plan with drug coverage, your participation in this payment option will end. However, you will continue to receive a monthly invoice for the amount owed until your balance is paid in full. If you enroll in a new plan with drug coverage, you may be able to rejoin the Medicare Prescription Payment Plan by contacting your new plan.
- While this payment option helps to manage your costs, it doesn't lower your costs. If you have limited income or resources, you can learn more about programs to help lower drug costs by visiting [Medicare.gov](http://Medicare.gov).
- If you have a concern, you have the right to follow the grievance process found in your Member Handbook or Evidence of Coverage.
- Express Scripts is administering this program on behalf of your Medicare Part D plan. If your address is different than what is on the form, you will need to work with your plan to update your address.
- If you suspect that your account or password has been compromised, please notify Express Scripts.
- Express Scripts works with a third-party supplier to offer the Medicare Prescription Payment Plan, including providing a website to view your account, schedule and make payments, and review payment history.

# PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at: **1-833-230-2020 (TTY: 1-833-711-4711 or 711)**.



## UNDERSTANDING THE BENEFITS

- The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs and benefits before you enroll. Visit **CareSource.com/DSNP** or call **1-833-230-2020 (TTY: 1-833-711-4711 or 711)** to view a copy of the EOC.
- Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- Review the formulary to make sure your drugs are covered.

## UNDERSTANDING IMPORTANT RULES

- You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- Benefits, premiums, and/or copayments/co-insurance may change on January 1, 2026.
- Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- This plan is a Dual Eligible Special Needs Plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid and are classified as Qualified Medicare Beneficiary (QMB), Qualified Medicare Beneficiary plus (QMB+), Specified Low Income Beneficiary Plus (SLMB+) or Full-Benefit Dual Eligible (FBDE).
- Effect on Current Coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage health care coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.



**IMPORTANT INFORMATION:**

**2024 Medicare Star Ratings**



CareSource - H6396

For 2024, CareSource - H6396 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★★★★

**Health Services Rating:** ★★★★★

**Drug Services Rating:** ★★★★★

Every year, Medicare evaluates plans based on a 5-star rating system.

**Why Star Ratings Are Important**

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan’s service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

**The number of stars show how well a plan performs.**

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

**Get More Information on Star Ratings Online**

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

**Questions about this plan?**

Contact CareSource 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 844-607-2830 (toll-free) or 833-711-4711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 833-230-2020 (toll-free) or 833-711-4711 (TTY).

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-833-230-2020**. Someone who speaks your language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-230-2020. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-230-2020。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-230-2020。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-833-230-2020. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-230-2020. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-230-2020 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-230-2020. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-230-2020 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**TTY: 1-833-711-4711 or 711**

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-230-2020. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-230-2020. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-230-2020 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-230-2020. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-230-2020. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-230-2020. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-230-2020. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-833-230-2020にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of age, gender, gender identity, color, race, disability, national origin, ethnicity, marital status, sexual preference, sexual orientation, religious affiliation, health status, or public assistance status. CareSource offers free aids and services to people with disabilities or those whose primary language is not English. We can get sign language interpreters or interpreters in other languages so they can communicate effectively with us or their providers. Printed materials are also available in large print, braille or audio at no charge. Please call Member Services at the number on your CareSource ID card if you need any of these services. If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

Mail: CareSource  
Attn: Civil Rights Coordinator  
P.O. Box 1947  
Dayton, Ohio 45401

Email: [CivilRightsCoordinator@CareSource.com](mailto:CivilRightsCoordinator@CareSource.com)  
Phone: 1-800-488-0134 (TTY: 711)  
Fax: 1-844-417-6254

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Mail: U.S. Dept of Health and Human Services  
200 Independence Ave, SW Room 509F HHH Building  
Washington, D.C. 20201

Online: [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf)

Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

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



CareSource Dual Advantage™ (HMO D-SNP)

# 2025 SUMMARY OF BENEFITS

# 2025 SUMMARY OF BENEFITS

## Introduction

**You deserve more. You deserve a health plan you can trust.**

CareSource is a nonprofit health insurance company that has been meeting the needs of health care consumers like you for over 30 years. Our mission is to make a lasting difference in our members' lives by giving them resources to improve their health and well-being. CareSource Dual Advantage™ (HMO D-SNP) gives you more benefits, more savings, more care... and no hidden costs.

## ABOUT THE PLAN

CareSource Dual Advantage is a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) plan with a Medicare and Medicaid contract. This means that in addition to CareSource Dual Advantage coverage, Ohio Department of Medicaid (ODM) also shares some of the cost for your health care services. How much Medicaid covers depends on your income, resources, and other factors.

If your category of Medicaid eligibility changes, your cost share may also increase or decrease. **You must renew your Medicaid enrollment to continue to receive your Medicaid coverage.**

## WHO CAN JOIN?

To join CareSource Dual Advantage you must meet the following:

- Be entitled to Medicare Part A;
- Be enrolled in Medicare Part B;
- Be enrolled in one of the following:
  - **Qualified Medicare Beneficiary (QMB):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayments amounts only.
  - **Qualified Medicare Beneficiary Plus (QMB+):** You get Medicaid coverage of Medicare cost-share and are also eligible for full Medicaid benefits. Medicaid pays your Part A and Part B premiums, deductibles, coinsurance, and copayment amounts.

- **Full Benefits Dual Eligible (FBDE):** Medicaid may provide limited assistance with Medicare cost-sharing. Medicaid also provides full Medicaid benefits. You are eligible for full Medicaid benefits. At times you may also be eligible for limited assistance from the State Medicaid Office in paying your Medicare cost share amounts. Generally, your cost share is 0% when the service is covered by both Medicare and Medicaid. There may be cases where you have to pay cost sharing when a service or benefit is not covered by Medicaid.
- **Specified Low-Income Medicare Beneficiary with full Medicaid (SLMB+):** You get Medicaid coverage of Medicare cost-share but are not eligible for full Medicaid benefits. Medicaid helps pay Part B premium amounts.
  - Be a United States citizen or lawfully present in the United States;
  - Live in our plan's service area.

The CareSource Dual Advantage service area includes the following counties in Ohio:

Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood, Wyandot

## WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

CareSource Dual Advantage has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are out of our network, the Plan may not pay for those services.

You must use network pharmacies to fill your prescriptions for covered Part D drugs.

You can go to **CareSource.com/DSNP** to view or search for a network provider or pharmacy using our online directories or call us and we will send you a copy of the *Provider & Pharmacy Directory*.

## TIPS FOR COMPARING YOUR MEDICARE CHOICES

This *Summary of Benefits* booklet is a summary of what CareSource Dual Advantage covers and what you pay.

- If you want to compare our plan with other Medicare health plans in your area, use the Medicare Plan Finder on [medicare.gov](https://www.medicare.gov).
- If you want to know more about the coverage and costs of Original Medicare, look in the *Medicare & You* handbook. View it online at [medicare.gov](https://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.

# Questions?

If you are currently a member of this plan, call us toll-free at **1-833-230-2020** (TTY users should call **1-833-711-4711 or 711**).

If you are not a member of this plan, call us toll-free at **1-844-607-2830** (TTY: **1-833-711-4711 or 711**).

You can also visit our website at **CareSource.com/DSNP**

## Hours of Operation

We are open 8 a.m. to 8 p.m. Monday through Friday, and from October 1 through March 31, the same hours seven days a week.

## Member Services

This document is available in other formats such as large print.

This document may be available in a non-English language. For additional information, call us at **1-833-230-2020**. (TTY users should call **1-833-711-4711 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 **1-833-230-2020**. (Los usuarios de TTY deben llamar al **1-833-711-4711 o 711**.)

MONTHLY PREMIUM, DEDUCTIBLE AND LIMITS	
	CareSource Dual Advantage
Monthly Premium	\$0
Annual Deductible (See the <i>Prescription Drug Coverage</i> section for the Part D deductible)	\$0
Annual Out-of-Pocket Maximum (the limit on how much you will pay in a year)	\$0 Annually for Medicare-covered services from in-network providers.

## CareSource Dual Advantage 2025 Summary of Benefits Chart

Cost sharing for Medicare-covered benefits in the chart below are based on your level of Ohio Department of Medicaid (ODM) eligibility. Your services are paid first by Medicare and then by Medicaid. If a benefit is used up by Medicare, then Ohio Department of Medicaid (ODM) may provide coverage. CareSource Dual Advantage will cover the benefits described below.

If you have questions about your Medicaid eligibility and what benefits you are entitled to, call Ohio Department of Medicaid (ODM), 1-800-324-8680 for TTY call 711 during the hours of 7 a.m. – 8 p.m., Monday through Friday; 8 a.m. – 5 p.m., Saturday.

A complete list of services can be found in the *Evidence of Coverage* (EOC). A copy of the *Evidence of Coverage* can be sent to you by contacting Member Services or visiting [CareSource.com/DSNP](https://www.caresource.com/DSNP).

<b>COVERED MEDICAL AND HOSPITAL BENEFITS — IN-NETWORK ONLY</b>		
If you use providers that are not in our network, you may be responsible for the full cost of these services.		
	<b>CareSource Dual Advantage</b>	<b>Ohio Department of Medicaid (ODM)</b>
<b>Inpatient Hospital Care<sup>1</sup></b>	Days 1 through 90; 60 lifetime reserve days \$0 copay per day	Covered
<b>Outpatient Hospital Care<sup>1</sup></b>	\$0 copay	Covered
<b>Ambulatory Surgical Center (ASC) Services<sup>1</sup></b>	\$0 copay	Covered
<b>Doctor's Office Visits</b>	<b>Primary care provider visit (PCP)</b> (Including Telehealth Visits)	
	\$0 copay	Covered
	<b>Specialist visit</b>	
	\$0 copay	Covered
<b>Preventive Care</b>	\$0 copay	Covered
<b>Emergency Care</b>	\$0 copay	Covered
<b>Urgently Needed Services</b>	\$0 copay	Covered
<b>Diagnostic Services, Labs, and Imaging<sup>1</sup></b>	<b>Diagnostic tests and procedures</b>	
	\$0 copay	Covered
	<b>Lab services</b>	
	\$0 copay	Covered
	<b>Diagnostic radiology services</b> (such as MRIs, CT scans)	
	\$0 copay	Covered
	<b>Outpatient x-rays</b>	
	\$0 copay	Covered

<sup>1</sup> Prior authorization is required for some services.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

**COVERED MEDICAL AND HOSPITAL BENEFITS — IN-NETWORK ONLY (continued)**

If you use providers that are not in our network, you may be responsible for the full cost of these services.

	CareSource Dual Advantage	Ohio Department of Medicaid (ODM)
<b>Hearing Services</b>	<b>Exam to diagnose and treat hearing and balance issues</b>	
	\$0 copay	Covered
	<b>Routine hearing exam</b>	
	\$0 copay, 1 every year	Covered
	<b>Hearing aids<sup>2</sup></b>	
\$0 copay TruHearing <sup>®*</sup> Advanced model hearing aids (available in rechargeable options), one per ear every 3 years <b>Hearing aid purchase includes:</b> – Provider visits within the first year of hearing aid purchase – 60-day trial period – 3-year extended warranty – 80 batteries per aid for non-rechargeable models	Covered	
<b>Dental Services</b> (continued on the next page)	<b>Medicare-covered services</b>	
	\$0 copay	Not Applicable
	<b>Preventive dental<sup>2</sup></b>	
\$0 copay for a single office visit that includes: Every six months: – 1 cleaning – 1 oral exam – 1 fluoride treatment Every year: – 1 dental x-ray	Covered	

<sup>2</sup> Services are not subject to the maximum out of pocket.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

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**COVERED MEDICAL AND HOSPITAL BENEFITS — IN-NETWORK ONLY (continued)**

If you use providers that are not in our network, you may be responsible for the full cost of these services.

	CareSource Dual Advantage	Ohio Department of Medicaid (ODM)
<b>Dental Services</b> (continued)	<b>Comprehensive dental<sup>1,2</sup></b>	
	\$0 copay Includes simple extractions, minor restorations, periodontics, and other non-Medicare covered comprehensive dental services such as dentures and implants	Covered
	<b>Preventive and comprehensive dental allowance</b>	
	\$6,000 maximum plan coverage amount for preventive and comprehensive dental benefits.	Not Covered
<b>Vision Services</b>	<b>Exam to diagnose and treat diseases and conditions of the eye</b>	
	\$0 copay	Covered
	<b>Routine eye exam (1 every year)</b>	
	\$0 copay	Covered
	<b>Eyewear<sup>2</sup></b>	
	\$0 copay \$600 maximum plan coverage amount every year for all non-Medicare-covered eyewear.	Covered
<b>Medicare-covered eyeglasses or contact lenses after cataract surgery</b>		
\$0 copay	Not Applicable	

<sup>1</sup> Prior authorization is required for some services.

<sup>2</sup> Services are not subject to the maximum out of pocket.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

**COVERED MEDICAL AND HOSPITAL BENEFITS — IN-NETWORK ONLY** (continued)

If you use providers that are not in our network, you may be responsible for the full cost of these services.

	CareSource Dual Advantage	Ohio Department of Medicaid (ODM)
<b>Mental Health Care<sup>1</sup></b> Lifetime limit: Up to 190 days inpatient care in a psychiatric hospital	<b>Inpatient visit</b>	
	Days 1 through 90; 60 lifetime reserve days \$0 copay per day	Covered
	<b>Outpatient group therapy visit</b>	
	\$0 copay	Covered
	<b>Outpatient individual therapy visit</b>	
	\$0 copay	Covered
<b>Skilled Nursing Facility<sup>1</sup></b> Limited to 100 days per benefit period	Days 1 through 100 \$0 copay per day	Covered
<b>Physical Therapy<sup>1</sup></b>	\$0 copay	Covered
<b>Ambulance<sup>1</sup></b>	\$0 copay	Covered
<b>Transportation</b>	<b>Plan approved health-related locations</b>	
	\$0 copay	Covered
<b>Medicare Part B Drugs<sup>1</sup></b> (including chemotherapy)	\$0 copay	Covered

<sup>1</sup> Prior authorization is required for some services.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.



## PRESCRIPTION DRUG COVERAGE

You can use our complete "Drug List" (Formulary) located on [CareSource.com/DSNP](https://www.caresource.com/DSNP) to find your drugs and to see if your drug has additional requirements or limits such as prior authorization or quantity limits. To get a hard copy, call us and we will send you a copy of the "Drug List."

For more information on the pharmacy-specific cost-sharing and the phases of the benefit, please call us toll-free at **1-833-230-2020** (TTY users should call **1-833-711-4711 or 711**) or access our website at [CareSource.com/DSNP](https://www.caresource.com/DSNP).

If you qualify for "Extra Help," you will pay \$0 for all Medicare Part D covered prescription drugs on your formulary and through all stages.

### PRESCRIPTION DRUG BENEFITS— IN-NETWORK ONLY

If you use pharmacies that are not in our network, you may be responsible for the full cost.

CareSource Dual Advantage	
Part D Deductible	\$0

**Below is what you pay for covered drugs in the deductible, initial coverage, and catastrophic coverage phase.**

### Standard Retail and Standard Mail Order Cost-Sharing

#### 1-month, 2-month, or 3-month supply

All covered drugs	\$0 copay
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**Some prescription drugs have additional requirements. You can look at our "Drug List" (Formulary) to see if your drug requires prior authorization or has quantity limits. Mail-order limited to 102-day supply.**

## Other Benefits CareSource Dual Advantage Offers

ADDITIONAL BENEFITS	
	CareSource Dual Advantage
<b>Acupuncture</b> (for chronic low back pain)	\$0 copay
<b>CareSource24® Nurse Advice Line</b>	<p>CareSource24 provides around-the-clock access to a caring and experienced staff of registered nurses. Members can call the CareSource24 toll-free number located on your CareSource member ID card 24 hours a day, 7 days a week, 365 days a year. CareSource24 services can be used at no cost to you. This provides you with an easy way to receive trusted health information and advice from the comfort of your home.</p> <p>Speaking directly with professional registered nurses can help you:</p> <ul style="list-style-type: none"> <li>– Decide when self-care, a doctor visit, or the emergency room is the right choice</li> <li>– Check your symptoms and help you figure out what to do</li> <li>– Understand a medical condition or recent diagnosis</li> <li>– Obtain medical information</li> <li>– Prepare questions for doctor visits</li> <li>– Find out more about prescriptions or over-the-counter (OTC) items</li> <li>– Learn about healthy eating and staying well</li> </ul>
<b>Chiropractic Care</b>	<p>\$0 copay</p> <p>Includes manipulation of the spine to correct a subluxation (when one or more of the bones of your spine move out of position)</p>
<b>Diabetes Supplies and Services<sup>1</sup></b>	<p><b>Diabetes monitoring supplies</b></p> <p>\$0 copay</p> <p>Diabetic supplies and services are limited to specified manufacturers:</p> <p>Blood glucose test strips and meters</p> <ul style="list-style-type: none"> <li>– Abbott Diabetes &amp; Lifescan products</li> </ul> <p>Continuous glucose monitors (CGMs)</p> <ul style="list-style-type: none"> <li>– Abbott FreeStyle &amp; Dexcom</li> </ul>
	<p><b>Diabetes self-management training</b></p> <p>\$0 copay</p>
	<p><b>Therapeutic shoes or inserts</b></p> <p>\$0 copay</p>
	<p><b>Durable Medical Equipment<sup>1</sup></b> (wheelchairs, oxygen, etc.)</p> <p>\$0 copay</p>

<sup>1</sup> Prior authorization is required for some services.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

## ADDITIONAL BENEFITS

### CareSource Dual Advantage

<b>Fitness</b>	<b>Physical fitness benefit</b>
	<p style="text-align: center;">\$0 copay</p> <p style="text-align: center;">Includes membership at participating fitness centers and home fitness kit (some kits include a wearable fitness tracker)</p>
<b>Healthy Benefits+™ Allowance</b>	<p>Members use the Healthy Benefits+ debit card to purchase up to \$255 per month for approved services and items from eligible locations, including:</p> <ul style="list-style-type: none"> <li>– Food &amp; Produce</li> <li>– Over-The-Counter (OTC) Items</li> <li>– Utility Expenses</li> <li>– Personal Care Items</li> <li>– Pet Care Items (excluding veterinary care and grooming)</li> <li>– Dental</li> <li>– Vision</li> <li>– Hearing</li> </ul> <p>Unused amounts rollover to the following month and will expire at the end of the year.</p>
<b>Home Health Care<sup>1</sup></b>	\$0 copay
<b>Hospice<sup>1</sup></b>	<p>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.</p>
<b>Meals</b>	Two meals a day for 14 days after each inpatient or skilled nursing facility stay
<b>MyHealth™ Online Tool</b>	<p>With MyHealth, you'll have online access to resources for your health, including:</p> <ul style="list-style-type: none"> <li>– Health assessments</li> <li>– Personalized online wellness plans</li> <li>– Step-by-step guides on specific health needs</li> <li>– Online health journeys</li> <li>– Goal setting and tracking</li> <li>– Health tips and wellness information</li> </ul>

<sup>1</sup> Prior authorization is required for some services.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

## ADDITIONAL BENEFITS

### CareSource Dual Advantage

<b>Outpatient Rehabilitation<sup>1</sup></b>	<b>Cardiac (heart) rehabilitation services</b>
	\$0 copay
	<b>Occupational therapy visits</b>
	\$0 copay
	<b>Speech and language therapy visit</b>
	\$0 copay
<b>Outpatient Substance Abuse</b>	<b>Supervised exercise therapy (SET)</b>
	\$0 copay
	<b>Group therapy visit</b>
<b>Outpatient Substance Abuse</b>	\$0 copay
	<b>Individual therapy visit</b>
<b>Outpatient Substance Abuse</b>	\$0 copay
<b>Personal Emergency Response System (PERS)</b>	A PERS consists of a home monitoring device that sends an alert to a 24-hour call center in the event of an emergency.
<b>Podiatry</b>	<b>Medicare-covered services</b>
	Includes foot exams and treatment if you have diabetes-related nerve damage or meet certain conditions
	<b>Routine Foot Care</b>
	\$0 copay Members get 6 additional visits per year for routine foot care
<b>Prosthetic Devices<sup>1</sup></b> (braces, artificial limbs, etc.)	<b>Prosthetic devices</b>
	\$0 copay
	<b>Related medical supplies</b>
	\$0 copay
<b>Renal Dialysis</b>	\$0 copay
<b>Therapeutic Radiology Services<sup>1</sup></b> (such as radiation treatment for cancer)	\$0 copay
<b>Worldwide Emergency Services, Urgently Needed Services, and Transportation</b>	\$0 copay \$10,000 maximum plan benefit coverage amount every year for the worldwide benefit.

<sup>1</sup> Prior authorization is required for some services.

Amounts shown are what you pay. Services are covered in-network only except for emergency services and urgently needed services.

This information is not a complete description of benefits. Call **1-833-230-2020** (TTY users should call **1-833-711-4711 or 711**) for more information. Limitations, copayments, and restrictions may apply.

Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. Plans may offer supplemental benefits in addition to Part C benefits and Part D benefits.

Out-of-network/non-contracted providers are under no obligation to treat CareSource members, except in emergency situations. Please call our customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

CareSource is an HMO D-SNP with a Medicare and state Medicaid contract. Enrollment in CareSource depends on contract renewal.

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-833-230-2020**. Someone who speaks your language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-230-2020. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-833-230-2020。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-833-230-2020。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasalang-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasalang-wika, tawagan lamang kami sa 1-833-230-2020. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-230-2020. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-833-230-2020 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-230-2020. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-230-2020 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**TTY: 1-833-711-4711 or 711**

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-833-230-2020. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-230-2020. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-230-2020 पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है। यह एक मुफ्त सेवा है।

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-230-2020. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portuguese:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-230-2020. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-833-230-2020. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-230-2020. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-833-230-2020にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of age, gender, gender identity, color, race, disability, national origin, ethnicity, marital status, sexual preference, sexual orientation, religious affiliation, health status, or public assistance status. CareSource offers free aids and services to people with disabilities or those whose primary language is not English. We can get sign language interpreters or interpreters in other languages so they can communicate effectively with us or their providers. Printed materials are also available in large print, braille or audio at no charge. Please call Member Services at the number on your CareSource ID card if you need any of these services. If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

Mail: CareSource  
Attn: Civil Rights Coordinator  
P.O. Box 1947  
Dayton, Ohio 45401

Email: [CivilRightsCoordinator@CareSource.com](mailto:CivilRightsCoordinator@CareSource.com)  
Phone: 1-800-488-0134 (TTY: 711)  
Fax: 1-844-417-6254

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

Mail: U.S. Dept of Health and Human Services  
200 Independence Ave, SW Room 509F HHH Building  
Washington, D.C. 20201

Online: [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf)

Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

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



[CareSource.com/DSNP](https://www.caresource.com/DSNP)



# WHAT HAPPENS NEXT

## What Happens Next as a New CareSource Dual Advantage™ (HMO D-SNP) Member?

Thank you for applying for the CareSource Dual Advantage plan. We are glad you have chosen us for your Medicare health plan needs. While we confirm your enrollment with Medicare, here's what you can expect in the next few weeks:



**1. CHECK YOUR MAILBOX!** Once Medicare confirms your enrollment, you will receive your **confirmation letter** and other applicable materials. If Medicare requires more information from you so that we can complete your enrollment, we will send you a notification to let you know next steps.



**2. YOU'LL RECEIVE YOUR NEW MEMBER KIT.** This will come in the mail approximately two weeks after the confirmation letter. This kit contains important information about your plan, the benefits and how to contact us if you need help.

Your CareSource member ID card will not be in the new member kit. It will arrive later in a separate mailing. Your CareSource member ID will be the only card you will need to show each time you get medical, dental, vision, hearing care, prescription medications or supplies.

If you don't receive your CareSource member ID card within 10 days of your effective date, please call Member Services at **1-833-230-2020 (TTY: 1-833-711-4711 or 711)** to have a new card mailed to you. We are open 8 a.m. to 8 p.m., Monday through Friday, and from October 1 through March 31, we are open the same hours, seven days a week.





### 3. YOU WILL HAVE SEVERAL OPTIONS TO COMPLETE A HEALTH NEEDS ASSESSMENT (HNA) AS PART OF YOUR ENROLLMENT.

The HNA is a screening that helps identify your preventive care needs and health concerns. Your completion of the HNA helps us work together to improve or maintain your physical and mental health. Members can earn rewards for your My CareSource Rewards® card for completion of the HNA.

-\$50 once completed after receiving eligibility.

#### **All Current Members**

\$50 – annual reassessment within 365 days of initial/continuously enrolled  
1x/calendar year.



You can complete the HNA online once your coverage begins by visiting **MyCareSource.com**. Click on the **Health** tab to begin the assessment.

If you prefer, you may complete the printed version included in your new member kit and return it with the included business reply envelope.

If you need help completing the assessment, call our Member Assessment Team at **1-833-230-2011 (TTY: 1-833-711-4711 or 711)**. Your enrollment specialist can help you complete this along with your application.



### 4. YOUR HEALTHY BENEFITS+ CARD WILL ARRIVE SEPARATELY

preloaded with allowances for food and produce, over-the-counter (OTC), utilities, pet care items, personal care items and flex benefits for dental, vision and hearing.



### 5. YOU WILL RECEIVE A CALL FROM OUR CARE MANAGEMENT TEAM

within the first 90 days of your membership. A nurse or outreach worker from our team will be able to help address special medical problems, coordinate your health care needs and more!

CareSource is an HMO D-SNP with a Medicare and a state Medicaid contract. Enrollment in CareSource depends on contract renewal.



**CareSource.com/DSNP**